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ABSTRACT

Seven papers address issues in service delivery of educational programs for emotionally disturbed students. M. Noel begins with "Public School Programs for the Emotionally Disturbed: An Overview," in which she reviews past and present approaches and models. In "Pathways to Success: Working with Seriously Emotionally Disturbed Students in a Public School Setting," R. Laneve reviews identification, evaluation, placement, and instructional approaches used at the Mark Twain School (Montgomery County, Maryland). Team functioning is the focus of "Service Delivery Teams: Definition, Processes, and Accountability" by L. McCormick. An integrated model for providing related services is offered by R. Grubb and M. Thompson in "Delivering Related Services to the Emotionally Disturbed: A Field-Based Perspective." Aspects of "Inservice Training for Teachers of the Emotionally Disturbed" are considered by R. Neel. Institutions, residential schools, group homes, foster homes, and hostels or respite homes are discussed by J. Seip and D. McCoy in "Alternative Living Arrangements for the Severely Behavior Disordered." Excerpts of interviews with parents of emotionally disturbed children are presented by M. Noel in "Parenting the Emotionally Disturbed Child: Personal Perspectives." (CL)

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PDAS
Program Development
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Progress or Change:

Issues in Educating the Emotionally Disturbed

Volume 2: Service Delivery

Edited by
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Preface

This monograph is the second of a two-volume set that addresses the issues involved in the education of emotionally disturbed children and youth. Volume I of this series deals with global policy issues such as definition and eligibility, as well as assessment and program planning and administration. This volume is focused on those issues that relate to actual service delivery. Included are the design of public school programs, the coordination of services, and the preparation of adequately trained personnel. Also included within this volume is a more personal, yet highly relevant, chapter devoted to the presentation of parents' views of the educational options being provided to their children.

This volume has been developed to represent the essential problem faced by special educators of the emotionally disturbed. For, despite the confusion inherent in the terminology and the resultant difficulties in program development and administration, a basic need exists for quality educational programs that can address the diverse academic, social, and emotional needs of these students. What is more, such comprehensive programs must be developed within the ambiguity of state and federal guidelines and regulations. The standards set by the profession for these programs, as for all special education programs, are high; however, the degree to which the standards are being met is questionable. Certainly the complexity of the needs, as well as the mixed history of the population, has influenced the nature of the service delivery.

The confusion is clearly evident in the very nature of the educational models that have been developed over the years. The additional needs to provide both crisis and long-term residential options, as well as support services such as family counseling or individual psychotherapy, have confounded the issues. Organizing programs that can incorporate such service needs is bound to present a challenge to an educational system. Still, a number of models do exist. In fact, the problem or issue does not seem to lie in any failure to pursue answers or solutions. Rather, the problem appears to be a failure to consolidate and interpret the various approaches, to evaluate results, and to pull together a set of comprehensible and effective approaches or models for education of the emotionally disturbed.

The chapters in this monograph address this need for consolidation and attempt to present a collection of information across several major service delivery issues. The chapters are not intended to serve as directives or prescriptions. Rather, the intent has been to collect and synthesize existing information and viewpoints in order to provide a tool for decision making. Thus, the ultimate value of this volume, and Volume I, should be judged in terms of the extent to which they have stimulated thinking and facilitated orderly and planned change.

N.G.H.
M.M.N.

Public School Programs for the Emotionally Disturbed: An Overview

Margaret M. Noel

Educational intervention and management of emotionally disturbed students have a relatively short history. Although public school programs began to be developed only about 25 years ago, there has always been a certain schizophrenia surrounding the responsibility for and nature of programs for the emotionally disturbed. These students have been, and to a significant degree continue to be, "treated" or "managed" in psychiatric or mental health facilities and "educated" in school programs. This chapter will focus on the nature of public school *education*. As such, it is limited to a review and discussion of some of the program models that can or do operate within the public schools.

Clearly evident from the review is that present public school programming for the emotionally disturbed lacks a unitary comprehensive conceptual model. Programs that have been developed for this population reflect several different theoretical approaches. These differences influence the programs in terms of focus of intervention as well as administrative arrangements. The diversity in programming appears to be, in large part, the result of at least one pervasive issue confronting the field of emotional disturbance. The issue of inadequate definition consistently emerged in the literature as a major impediment to the provision of special education services and reflects the complexity of the problems presented to educators who work with behavior disordered children and youth.

This chapter has been organized to present a brief historical review of general programming efforts and an overview of the major conceptual models that have developed within special education for the emotionally disturbed. Finally, examples of current programming strategies will be presented and recommendations, or at least, observations regarding future directions will be suggested.

History

Special education for the emotionally disturbed has a relatively short history. Paul and Warnock (1980), in an overview of the changes that have occurred within the field, note that educational responsibility for the emotionally disturbed did not become a major emphasis until the early 1960s. Prior to that time, these students were generally considered to be the responsibility of the mental health system. Paul and Warnock attribute the shift in responsibility to several factors, including a lack of mental health professionals, a growing realization that psychiatric and institutional treatment were inadequate as well as inhumane, and a questioning of the legitimacy of use of the medical paradigm of emotional "sickness" or "illness."

The failure of the mental health movement of the 1930s and 1940s to deal effectively with the emotionally disturbed provided the major impetus for the development of special programs for these youth within the public schools (Haring & Phillips, 1962; Morse, Cutler, & Fink, 1964). Whether due to lack of resources, such as manpower, or of a basic knowledge base, child guidance clinics, mental health centers, and other similar psychiatrically oriented facilities were failing to meet the needs of the emotionally disturbed. Not only were the programs in these facilities ineffective, they were, in fact, considered to have negative effects on children because they necessitated the separation of the child from the home and community.

The more mildly to moderately emotionally disturbed, not considered serious enough for institutional placement, had no options. They frequently dropped out of school or, more likely, were given disciplinary expulsion, considered unteachable, and removed from the school system (Paul & Warnock, 1980). In general, the public schools had few programs and few intervention models, and furthermore, had no useful way of classifying these students. In 1948 only 90 school districts in the entire United States were operating programs for the emotionally disturbed (Mackie, 1969). In 1958, as the dissatisfaction with the mental health movement reached crisis proportion, Knoblock (1963) sampled 5000 public school districts in the U.S. and found that only 500—a tenth—were providing some sort of service to emotionally disturbed students.

As educational programs and services began to be developed in the late 1950s and early 1960s, the lack of a common set of characteristics or classifications for the emotionally disturbed student began to be noted. Knoblock (1963), citing the reasons for the slow development of emotionally disturbed programs, noted the problem of the wide array of symptoms and characteristics presented by these students. He felt that this diversity, coupled with the related problem of role conflict between educators and mental health professionals, had resulted in confusion and a lack of cohesive program models for public schools. Earlier Quay (1963) cautioned that, while public schools may have been in a rush to create programs for the emotionally disturbed in response to community demands, the field had inadequate knowledge about these students to guide program development. In particular, he expressed concern that classifications, placements, and programs were being based on clinical impressions and quasi-personality theory and were failing to recognize the variety of behaviors exhibited by these students.

In fact, many early programs for the emotionally disturbed were marked by a confusion over the role of mental health and traditional psychodynamic treatment models and that of education. Lacking both a body of empirical knowledge regarding treatment or management and a concept of emotional disturbance, public schools developed programs that ran the gamut from psychiatric to traditional education. The results of two surveys of public school programs conducted during the 1960s, the well-known Morse, Cutler, and Fink (1964) study, and a national survey conducted by Adamson (1968), both demonstrated this lack of a common conceptualization for emotional disturbance and program orientation.

One of the major observations noted by Morse and his colleagues was the variability in classifications and definitions used by states. While some states maintained a very clinical psychological classification system, others varied between the more behavioral and descriptive to defining emotional disturbance as simply "socially maladjusted." The programs provided by the schools reflected the same lack of cohesiveness and were characterized by general goals and a variety of administrative arrangements and philosophical orientations.

Morse identified seven categories of programs that were in operation across the states. These included: 1) psychiatric dynamic—programs in which education played a secondary role to "therapy"; 2) psychoeducational—programs representing a blend between psychodynamic concepts and education; 3) psychological-behavioral—programs based on learning theory and representing a more structured approach; 4) educational—programs characterized by formal, accepted, regular education procedures and curricula, with little or no theoretical design; 5) naturalistic—programs with no specific design or organized approach in which teachers responded to behavior as it came; 6) primitive—programs with aloof teachers who maintained control through domination and fear; and 7) chaotic—classes in which there was no order or no organized program. The type found most often was the formal educational variety, followed by the psychoeducational approach. Regardless of philosophical orientation, however, all of the school programs tended to exist in isolation from other treatments or interventions. There was little or no communication or cooperation with other agencies or individuals serving the emotionally disturbed student; thus, no continuity of treatment existed across settings. In addition, while these programs were in public schools, they were frequently run in special segregated classrooms, and only a third provided some degree of integration of the emotionally disturbed students with nonhandicapped peers.

Adamson's (1968) survey provided some substantiation that programs for emotionally disturbed were growing. He identified a total of 2,800 classrooms in the United States which were serving 35,000 children. Seventy-five percent of these classes, however, were in states that had no requirements for specially trained teachers or provided any program guidelines. This lack of program direction was also noted by Knoblock and Johnson (1967) in the *Proceedings of the Third Annual Conference on the Education of the Emotionally Disturbed*. However, while they recognized the conceptual and organizational problems within the field, they were optimistic that the public schools were beginning to define better their role as service providers. They expressed optimism that there was impetus from within the field for change and that, coupled with increases in federal funding, a wide range of programs with proven effectiveness would be developed.

This optimism was not realized, however, as the situation did not improve during the early part of the next decade. Schultz, Hirshoren, Manton, and Henderson (1971), reporting data from a survey conducted in 1970 of all 50 states and the District of Columbia, found that six different terms were being used to define emotional disturbance, and while a range of 12 different service delivery options was defined, there was no consistent methodology for program organization. They too attributed the scattered and slow growth of programs and services to the problems in defining and identifying the population. In terms of service delivery arrangements, they found that the most frequent service option being provided was the special class (47 states). Forty states reported having resource room programs for emotionally disturbed students. Thirty-eight states, however, also indicated that homebound instruction was a frequently used option. Of particular note is that no measures of program effectiveness were provided by any state. This lack of program evaluation data was also noted by Vacc (1972), who questioned the fact that the professional literature was concentrating on describing projects or suggesting methodologies, but was providing little data on overall program effectiveness.

Even with the lack of data, some positive trends were becoming apparent at the beginning of the 1970s. Most notably there appeared to be a shift toward more integration of the emotionally disturbed into the regular education mainstream through use of resource rooms or a form of consultant-teacher models. There was also a recognition of the importance of developing comprehensive community-based treatment programs that involved the public schools as the major "treatment" option, in cooperation with other child-centered agencies (Joint Commission on Mental Health of Children, 1970). The notion that special education was pivotal in the overall programming for disturbed children seemed firmly established. Some individuals, notably Morse (1970), remained concerned that public school programs for the emotionally disturbed continued to be "muddled," and that existing programs were characterized by "futility." He felt that the public schools had lost confidence in all the traditional treatments, but were still without a unified treatment approach.

The decade of the 1970s saw some of the most massive changes in special education. The national right-to-education movement resulted in the Education for All Handicapped Children Act that became Public Law 94-142 in 1975. This law, which has the reputation of being the most comprehensive piece of federal legislation in the field of handicapped education (LaVor, 1977), created a federal mandate that all handicapped children be provided a free and appropriate public education. With this new legislative mandate, public schools began to spur development of educational programs for their handicapped students. The impact of PL 94-142 on the education of handicapped children has been monumental. The effect on service delivery to the emotionally disturbed, however, may be questionable. First, there was the lack of a unifying theory that could serve as the basis for program development (Apter, 1977; Paul, 1977; Rhodes & Paul, 1978). In addition, there was concern that programs were not "flexible" or eclectic enough to match the wide range of characteristics of the emotionally disturbed. A second area of concern surrounded the concept of education in the least restrictive environment (LRE), which required public schools to provide a continuum of service options, such as special classes and resource rooms, which would allow for placement based on educational need and not on disability label.

From the inception of the field, the trend had been to segregate the emotionally disturbed from the nonhandicapped to "relieve tensions" and to protect the nonhandicapped. In 1979, Hirshoren and Heller published the results of a national survey of services being provided to behavior disordered adolescents. While they were specifically interested in secondary programs, they felt that many of the data reported reflected program development for all behavior disordered students. Once again, the most frequently utilized service model was the special segregated classroom. In addition, while 42 states had their programs administered by LEAs, some states turned their program administration and operation over to state hospitals or private mental health facilities.

Perhaps the most current statement regarding educational service delivery was compiled by the National Needs Analysis Project (Grosenick & Huntze, 1980). This project collected and analyzed data from a number of sources, the most extensive being the Annual Program Plans submitted by states to the Special Education Programs (formerly the Office of Special Education). Information was collected on a number of major issues, including definition, teacher training and certification, personnel, and service delivery options. The results of this survey do not speak well for the growth of the field. The most striking statistic is that, even based on conservative estimates, it appears that three-fourths of the children and youth with serious behavior disorders, some 741,000 students, were not being provided special education services. In addition, the report indicated that there was a prevalent feeling within the field that many of the programs that did exist were inappropriate or of poor quality, primarily because of the lack of trained and certified teachers.

In terms of service delivery, the survey did find that between 85 and 95% of all students who were labeled "Seriously Emotionally Disturbed" were being served in public school facilities. In addition, most states indicated that they provided several types of program options; however, the most commonly used option was still the within-district special class. Some variety of resource room was the next most frequent option, although the report stated that districts fluctuated greatly in use of this type of program.

With respect to use of more restrictive placements, such as special day schools, residential placement, or homebound instruction, states varied considerably. In several states where such options were used, emotionally disturbed students were placed more often than those with other types of handicaps. The data on use of homebound instruction were particularly notable, as nearly 40% of all handicapped students who were receiving this service were identified as "Seriously Emotionally Disturbed." The report concluded that these dismal statistics may be indicative of the overall "frustration and difficulty" public schools face in dealing with these students.

After nearly two decades of public school involvement with the emotionally disturbed, one must question the progress that has been made in providing educational services. Despite the influx of federal monies and the creation of legal mandates for service, the optimism expressed by Knoblock and Johnson in 1963 has not been confirmed. However, neither the dismal statistics nor the professional lamentation reflect a total lack of progress in the development of interventions or programs. In fact, there has been, from the field's inception, a body of literature that represents several schools of thought or conceptual models related to identification of and intervention with the emotionally disturbed. The major models have been identified and organized through the work of William Rhodes and Michael Tracy and their colleagues at the University of Michigan (Rhodes & Tracy, 1972 a, b). They identified six basic conceptual models for intervention with emotionally disturbed. While all six models have contributed to the general knowledge base in the area of emotional disturbance, four of the models, the psychodynamic, the psychoeducational, the behavioral, and the ecological, have had more wide-reaching applications within the public schools. These four models for intervention will be reviewed briefly in the following sections. In addition, a fifth approach or model, the psychoneurological, will also be discussed. While this approach was initially more closely identified with education of the "minimal brain damaged" student, it was not uncommon for children who exhibited behavior disorders such as impulsivity and hyperactivity, or who were generally acting out, to be diagnosed and treated as minimally brain damaged (Clements, 1966).

Conceptual Models

The six conceptual models, identified by Rhodes and Tracy, were drawn from the literature in the field of emotional disturbance and include: biophysical theory, psychodynamic theory, learning theory, ecological theory, sociological theory, and counter-theory. Each model is defined by its basic principles or theories regarding the origin of behavioral deviance as well as the nature of its interventions. The influence of each of these models on special education progress has varied over the past 20 years. However, as noted earlier, four of the models have had a more pronounced impact on educational programming.

Psychodynamic and Psychoeducational Models

Perhaps the most prevalent intervention models in the late 1950s and early 1960s were the psychodynamic and the psychoeducational. The former were derived from traditional psychoanalytic theory, with its emphasis on internal states and its focus on the subconscious as the cause of disturbance. Intervention strategies were focused on individual therapy. Two approaches that epitomized the psychodynamic model were developed by Berkowitz and Rothman (1960) and Redl (1959). In general these approaches viewed education as an extension of the therapy process. The basic goals for programs within those models reflect classical psychodynamic therapy, with its concern for id, ego, and superego. Education was oriented toward achieving self-awareness and knowledge of the environment, building relationships with others, and in general, defining and building the ego.

Thus, the educational programs organized within these models were characterized by a more permissive approach, stressing communication, "active" learning, sensory involvement, and child-defined goals. The curriculum and learning activities focused on the student's feelings and encouraged exploration of inner thoughts and expression of feelings.

The traditional psychodynamic therapeutic models constituted a major approach to treatment of emotionally disturbed children at all levels of severity. As public schools began to assume primary responsibility for the education of the emotionally disturbed, however, it became apparent that the psychodynamic model was neither cost effective nor time efficient. Specifically, it was not appropriate for classroom adaptation because treatment methodology relied exclusively on the direction of psychiatrists, child psychologists, and other clinical professionals. The recognition of the importance of education in its own right became the major impetus for development of the following models.

The psychoeducational model emerged in the late 1950s (Long, Morse, & Newman, 1971; Morse, 1975) and represents a compromise between education and psychotherapy. While psychoeducational programs recognized the importance of the individual child's psycho-social developmental level as well as the internal dynamics of behavior, they also stressed the importance of education and achievement in the total treatment plan. Special education teachers were not viewed as mere technicians operating at the direction of psychiatrists, but rather as program managers who used clinicians as adjuncts.

Psychoeducational programs were focused on "therapeutic education" (Morse, 1976) and were guided by educational goals and objectives and characterized by comprehensive assessment, including psychological and educational measurement. Individualized instruction plans were based on both academic achievement and the student's emotional and social developmental levels. While the need for classroom "limits" and structure was noted, there was also concern for developing a warm and accepting learning environment, fostering positive relationships between teacher and child, and strengthening the child's sense of self-control.

The content of individual school programs was compatible with both the student's educational and emotional needs. As such, educational experiences, including behavior management, were utilized to help the child cope with the daily environment. The "crisis teacher," a concept developed by William Morse (1976), is perhaps one of the clearest examples of the blend of education and psychological therapy in the psychoeducational approach to managing the emotionally disturbed student. This individual, a combination of a special educator and clinical worker, serves as a resource to the classroom teacher, and can work as tutor as well as quasi-therapist in assisting children in dealing with their behaviors.

The psychoeducational model became one of the first *educational* approaches to programming for the emotionally disturbed. At the same time that Morse and his colleagues were defining this concept of "clinical" education, however, a new educational technology, based on the concepts of learning theory, began to surface in special education.

Behavioral Model

The behavioral approach to management of the emotionally disturbed in public schools first began to reach prominence with the publication of the Haring and Phillips (1962) work, *Educating Emotionally Disturbed Children*. The authors presented a model for programming for the emotionally disturbed, which was founded on the basic premises of learning theory. The strategies of the program incorporated principles such as reinforcement and extinction within a structured, orderly environment that included reduced stimuli, direct instruction, and immediate feedback. Another major example of a program based on behavioral principles was the Engineered Classroom developed by Hewett (1968).

The behavioral programs were guided by the principle that the behaviors exhibited by emotionally disturbed students should be the focus for "treatment." While the behaviorists were not unconcerned about the student's feelings or the need for an accepting environment, the programs focused on the precise identification of maladaptive or "disturbed" behaviors, identification of the events in the immediate environment which maintained that behavior, and changes in the environment which facilitated the learning of appropriate behaviors.

The behavioral model places responsibility for the education of the emotionally disturbed squarely on the special educator, whose role is that of learning specialist. The role of the clinician is moved outside the classroom, and the development of specific academic skills and appropriate behaviors becomes the goal of the intervention strategies.

Like the psychoeducational model, the behavioral model espoused individual assessment and individualized instruction. In the latter model, however, assessment consists of direct observation, and results in the precise definition of observable behaviors, as opposed to the clinical interpretation of those behaviors. Instructional programming in both cases recognizes that learning does occur in stages or sequences. The behaviorist, however, does not define a child's level of instruction in terms of normalized theories of emotional or affective development. Rather, learning sequences or hierarchies are derived from the principle of behavior shaping.

While the behavioral model and the psychoeducational model dominated the field during the 1960s, the end of the decade saw the rise of a fourth major conceptual model, based on the ecological perspective.

Ecological Model

The ecological theorists assume what they call an "interactionist perspective" (Paul & Warnock, 1980). That is, emotional disturbance is viewed as an interaction between the individual's behavior and the norms and expectations of the environment. As such, this perspective incorporates thinking from sociology as well as developmental theory and focuses on the discrepancy between what an individual is doing and what his or her "normal" peers are doing. Accordingly, these theorists acknowledge that specific behaviors are contingent upon events and expectations from the environment. Educational interventions are thus designed to include the total environment in which the child is expected to function.

Two of the major proponents of ecological interventions include William Rhodes (1967, 1970) and Nicholas Hobbs (1966). Hobbs's Re-Education (Re-Ed) Program, initially developed as a residential program, provides comprehensive intervention or treatment, including active participation of families, schools, various child service agencies, and neighborhoods. The major goals of Re-Ed encompass both positive academic and behavioral changes in the child, as well as change in the child's ecology or environment. Education is a major component of the ecological approach—a recognition of the learned nature of behavior. As such, education becomes the major strategy for changing the child's behavior as well as the behavior of those with whom he or she interacts.

Psychoneurological

Among the early public school programs for handicapped students were those based on psychoneurological or biophysical theories. These programs focused on specific behavior disorders that were seen as a result of a dysfunction within the central nervous system. Major researchers and theoreticians representing this school of thought have included Strauss and Lehtinen (1947), Cruickshank, Bentzen, Ratzeburg, and Tannhauser (1961), and Rapaport (1951), and the major educational intervention or treatment strategy that grew out of this perspective has been called the structured approach.

Specific treatment plans included an in-depth analysis of an individual's strengths and deficits; the development of an individual educational prescription, focusing heavily on motor, perceptual, and attentional disorders; and the management of behavior through use of a structured or stimulus-controlled environment. As hyperactivity and poor impulse control are characteristics shared by the minimally brain damaged and many "emotionally disturbed" students, some programs for the latter incorporated the structured environment into their design.

Only five of the more dominant conceptual models for intervention in education for the emotionally disturbed have been reviewed; it should be acknowledged, however, that other models, specifically the humanistic and counter-culture, have contributed to development of programs. For a more thorough review, the reader is referred to Rhodes and Tracy (1972 a, b).

The next section reviews the more current literature and attempts to provide focus to what is currently being done to educate the behaviorally disturbed or emotionally disturbed students within the public schools. Particular attention has been devoted to identifying trends in the conceptual orientations of programs as well as to examining the nature of services that are being provided to these students. The review was limited to the programs either known to be currently in operation or those that have been reported in the literature over the past ten years. The specific intent was to determine if an organizing framework or a general conceptual model for educating emotionally disturbed students is evident within the field.

Current Approaches

The lack of a consistent approach to programming for the emotionally disturbed student has long been discussed. Harshman (1969) cited the wide variety of approaches in use during the 1960s, and eight years later, Paul (1977) and Feiner and Tarnow (1977) were all decrying the lack of a single organizing framework or model. While there appeared to be less reliance on psychodynamic approaches and more eclecticism, a need for coordinating and integrating services across agencies was cited. While these authors believed that services should be delivered by the public schools, they also felt that the services should be developed in coordination with other disciplines, such as medicine, psychiatry, and social work. This need for combining services "to provide flexible adaptations of intervention" also was noted by Wood (1979), who felt that pure educational interventions were limited. In addition, Wood specifically noted the need for eclectic and flexible interventions, ranging from highly-structured environments to the more unstructured and "therapeutic" classrooms.

Recently several trends in programming for the behaviorally disordered have been identified (Stainback & Stainback, 1980). These include increased application of "direct and functional methods for identification and programming" as well as intensive, individualized instruction. In addition, these authors note a trend in educational programs to focus on a student's total environment and to move away from isolated treatments. These statements would suggest that the field is, at last, responding in an organized fashion to the educational needs of the emotionally disturbed student. However positive this may appear, the authors did not provide specific examples of programs.

Therefore, a review of programs seemed justified, if only to confirm the aforementioned trends. The programs reviewed were drawn from those reported in the professional literature as well as from a review of 30 current federally funded model demonstration programs that are serving emotionally disturbed students (Mirkes, 1981). For purposes of organization the programs have been divided into the following categories: 1) basic instructional, 2) instructional and adjunct services (such as therapy or vocational), 3) supplemental program, 4) special schools, and 5) preschool programs. Each program was examined in terms of its major focus according to category as well as its conceptual or theoretical approach.

Instructional Programs

These programs, defined by their basic emphasis on academic instruction, represent by far the largest category. This should come as no surprise, as basic academic instruction has long been advocated for programs for the emotionally disturbed (Haring & Phillips, 1962; Hewett, 1968; Morse, 1976). Among the recent programs reviewed, some clearly adhered to a specific identifiable model or theoretical orientation, while others appeared more eclectic or were undefinable.

Among the 30 federal projects that reported serving "seriously emotionally disturbed" students, eight have a basic educational focus, including in-depth assessment of academic achievement, assessment of behavior problems, and the subsequent development of prescriptive educational plans. While differences exist among these programs in terms of specific curricula, they are alike in terms of their orientation to academic instruction. Four of these programs are noncategorical and include variations on the basic instructional approach, such as use of peer tutors or a computer system for generating instructional objectives and daily programs (Mirkes, 1981).

The general literature was perhaps less definitive, perhaps due to the move toward noncategorical programs for the mildly to moderately handicapped. Since the mid-1970s there has been a focus on children with learning *and* behavior disorders (see Blankenship & Lilly, 1981; Hallahan & Kauffman, 1977; Hammill & Bartel, 1978; Stephens, 1977; Wallace & Kauffman, 1978). Despite the inclusion of behavior disorders, the bulk of these programs is more commonly referred to as learning disabled programs. In general, they include precise academic assessment, individualized programming, and direct instruction. The present review was limited, however, only to specific programs that reported serving the emotionally disturbed or behavior disordered. The majority of these instructional programs were described primarily as mainstreaming programs designed to maintain or reintegrate the emotionally disturbed student in the regular classroom.

Consultant or Support Models. Among the variations of the instructional program, the consultant model (Blankenship & Lilly, 1981; Nelson & Stevens, 1981; Tharp & Wetzel, 1970) was one of the more widely used. This model involves the provision of support services and training to classroom teachers who are in turn responsible for delivering service directly to the student who is experiencing learning problems or exhibiting inappropriate behavior.

One variation of this model was described by McGlothlin (1978), who developed a School Referral Committee (SRC) comprised of regular classroom teachers, special education teachers, a school psychologist, and the building principal for the purpose of receiving referrals, defining specific student problems, and developing classroom-based interventions. The major purpose of the SRC is to maintain the student in the regular classroom. Thus, in this model, classroom teachers are heavily involved in developing specific realistic interventions and are provided with direct assistance and training in implementing the interventions.

Wixson (1980) also reported a successful implementation of a variation of the consultant model in an educational service district in Pennsylvania. In this program the special education teacher provided direct service to learning and emotionally disordered students in a special resource room, and indirect services, such as assessment, evaluation, and teacher consultation, in the regular classroom.

Nagrodsky (1977) utilized a team approach, including special education teachers and a Title I reading specialist, to provide consultation on program modifications and support to regular classroom teachers who had emotionally disturbed and learning disabled students in their classes. A somewhat less academic approach reported by Carroll et al. (1978) was essentially a modification of the crisis teacher approach in that the special teacher provided support and consultation to regular classroom teachers in the management of behavior and academic problems of mainstreamed emotionally disturbed students. The special teacher also served as a back-up teacher responsible for counseling students in crisis.

A major variation of a consultant model is the Adaptive Learning Environments (ALE) model, which has been developed by Wang and her colleagues at the University of Pittsburgh. The ALE is a noncategorical model that calls for the provision of special education services within the context of the regular classroom. Thus, any child who is experiencing learning or behavior problems can receive services within the regular classroom either directly from a specialist or from the classroom teacher in cooperation with the special teacher. In the latter case, the specialist assists the classroom teacher in modifying or adapting the child's academic program and learning experiences (Mirkes, 1981).

Alternative approaches focusing on educating the emotionally disturbed student within the regular classroom have included both direct instruction to teachers and provision of special programs or materials. Two recent examples of such an approach are those developed by Edwards (1980) and Kaeck (1978). Both utilize an external behavior manager who develops individual student management programs, modifies curricula and provides training to teachers in implementing the programs. Walker and his colleagues (Walker & Hops, 1979; Walker, Hops, & Greenwood, 1976) developed four comprehensive behavior management packages, CLASS, PEERS, PASS, and RECESS, designed specifically for use by classroom teachers. These packages, which contain identification and assessment criteria, include specific interventions for use with children who have low academic skills, are acting out, withdrawn, or aggressive. The packages provide a systematic approach for pinpointing problem behaviors and selecting an appropriate target behavior for training. They focus on maintaining the behavior disordered student in the regular classroom.

A final example of a consultant or support approach is one based on ecological and developmental theory, which has been developed by the Intervention by Prescription Project at the University of Michigan—Dearborn. This program utilizes a full-team approach; the team consists of special teacher, diagnostician, psychologist, and social worker. The team conducts an ecological assessment of children who have been referred from the regular classroom for behavior problems and then develops individualized interventions that match both the developmental level and the specific environment of the child (Mirkes, 1981). Again the major intent is to maintain the child in the regular classroom.

Direct Service Programs. Other programs included within the instructional category are those designed to provide direct services to the behaviorally disturbed student, either in a self-contained classroom or in a resource room within a public school. While the resource room is considered the most common of the current placement options (Grosenick & Huntze, 1980), few resource rooms designed specifically for behaviorally disturbed students were reported in the literature. This is perhaps a sign that few resource programs are designed solely for the behaviorally disordered, but rather are noncategorical programs that serve all mildly handicapped.

Two resource programs that were reported as specific to behaviorally disordered students were developed by Klein (1980) and Toker and Hoeltke (1978). The former, which operates in a junior high school in Minnesota, provides one to three hours a day of specialized academic instruction along with a systematic behavior management program. The program utilizes behavioral contracts and a token system that includes awarding points for demonstrating appropriate behaviors within the regular classrooms.

The second program is described as a basic resource room approach for behaviorally disturbed students in which the intervention plans focus first on the student's behaviors and "attitudes" and then on the individual academic needs. Specific techniques employed include providing structure, developing communication abilities, developing "awareness" and interests, and encouraging self-expression.

The paucity of published information about specific resource or special class programs for behaviorally disturbed students should not suggest that these options are less than satisfactory or that they are not prevalent approaches. In fact, the author's experience with federally funded demonstration programs and the school districts in which they operate has indicated that the basic placement options for behaviorally disturbed students across the nation are, in fact, resource rooms and/or special classes, supporting the Grosenick and Huntze data. The interventions observed within these classrooms almost uniformly focus primarily on academic skill remediation and incorporate some basic behavioral technology into the management of behavior.

Within the general category of "instructional programs," it appears that the behavioral model has had a major influence, particularly as evidenced by the emphasis on direct assessment and instruction. The efficacy of the basic academic orientation with behaviorally disabled students has been demonstrated in the past (Glavin, Quay, & Werry, 1971), and if the numbers of instructional programs are indicative of the future, it will undoubtedly remain a major program type for the emotionally disturbed student in the public school.

Adjunct Service Programs

A second category of programs includes those that provide general academic instruction with additional services, such as psychological counseling, psychiatric treatment, social skill training, or vocational training. The most common of those programs involve cooperative arrangements between the public school and a community mental health agency. The defining characteristics of the programs include a structured academic remediation program and the provision of some type of individual or group therapy, provided by mental health professionals. Thus, specific attention is given to the causes of the emotional disorder underlying the maladaptive behaviors. While the notion of providing therapy within a school-based program is closely aligned with both the psychoeducational and Re-Ed models, many of the current programs within this category have strong behavioral orientations, particularly those operating in the classroom setting.

The concept of providing mental health services in conjunction with the public schools is not new. Knoblock and Garcea (1965) proposed a model that utilized mental health professionals in public school classes to provide both direct therapeutic counseling to students as well as training to teachers. In 1970, Clarizio and McCoy, noting the fragmentation of services which exists when both the mental health agency and public school are intervening with behaviorally disordered students, proposed a centralization of services. They recommended that the public school become the treatment site for the emotionally disturbed student and that mental health professionals provide consultant services, such as diagnostic evaluation, teacher support, and emergency or crisis treatment.

Among the current programs, there are essentially two types of school/mental health agency arrangements. The first involves a special class or resource room placement within a public school setting, staffed with special education teachers who work in direct cooperation with mental health counselors or psychologists. An early example of this model was reported by Marrone (1970). This program consisted of special classes that operated within a regular public school. The intervention plan included intensive academic remediation, chemotherapy, group and individual therapy, and some behavioral interventions. Mental health professionals provided direct services to students, including group and individual therapy as needed within the mental health setting.

A similar school/mental health agency cooperative program that operates within the regular public school building is Project TOPS in Dade County, Florida (Mirkes, 1981). Students are provided academic instruction within a special self-contained class, modeled after Hewett's Engineered Classroom. As part of their total educational plan, therapeutic services are provided directly by mental health counselors working within the public school building. Another program also reported in Dade County combines a behavioral and psychotherapeutic approach (Lillesand, 1977). This special class program, designed for severely behavior disordered elementary age students, is sponsored by the Department of Youth Services and operates in cooperation with the public schools. The special classes, located in classrooms outside of the public school building, provide instruction focused on developing appropriate classroom behaviors, such as attention to task and independent learning, while providing remediation of academic deficits. The students progress through a series of steps, beginning with a highly structured token economy that is faded until students are receiving naturally occurring reinforcers and are phased back into the public school. Therapy and counseling are provided to students and families on an as-needed basis.

Another version of the school/mental health model, reported by Purdon (1979), is based on Redl's "therapeutic milieu" concept, and incorporates basic therapy into the total educational program. This public program school employs the combined resources of the public school and the community mental health agency. The student's "educational" plan stresses group process goals, individual therapy and counseling, and related psychotherapeutic interventions. A further example of the dual approach to intervention with the emotionally disturbed is a program operated at Children's Hospital in San Francisco (Linnibran, 1977), which provides a partial day program for behavior disordered adolescents. The program consists of individual and group psychotherapy and provides structured social interaction through art and recreation. Students participate for three hours a day and for the remainder of the time are involved in normal community programs, such as public school or vocational training. The center program is designed to support and subsidize, rather than supplant, existing educational services. A final variation of the adjunct service model involves those programs that provide counseling or group therapy as a resource program within the school. Unlike the more formal cooperative programs, these programs use mental health services on an individual basis to support the behaviorally disordered students who are being maintained in or reintegrated into mainstreamed settings (Patton, 1979; Thompson, 1978; Wasserman, 1976).

The next category of programs includes the supplemental programs, such as the alternative programs, as well as programs that supplement basic academic or instructional programs. Included among the latter are vocational programs and programs designed to teach specific social or school survival skills.

Special Programs

One could assume that this section might include reviews of alternative programs or those that provide instruction or training which does not follow the traditional educational curriculum. Such programs have generally been designed for adolescents and have been mentioned as an option for the adolescent behavior disordered student (Kauffman & Nelson, 1977). However, as Grosenick and Huntze (1980) note in their review, emotionally disturbed students are, in fact, usually not served in these programs, as evidenced by the lack of such programs in this present review.

Vocational/Career Awareness

The best approximations to the concept of an alternative program that were reported in the literature are the vocational and career awareness programs which have been developed for the mildly handicapped. These programs are generally designed for junior high and high school students and employ specialized curricula designed to increase career awareness. In general they also provide structured and systematic training of critical employability skills, such as communication and social interactions. In addition, the programs offer functional skill training in reading and computation as an alternative to the standard school curricula for those students with significant achievement deficits.

One example of a comprehensive vocational program is the Experience Based Career Education (EBCE) model. Initially developed in the late 1960s by Appalachia Regional Education Laboratory, this model has been successfully replicated with mildly handicapped adolescents (Mirkes, 1981) and constitutes a total vocational program. While there are a number of variations, the basic program provides structured career awareness, through both classroom activities and on-site job sampling, and then moves students into employment sites for training. Intensive support and supervision are provided to students and employers. In the latter case EBCE staff provide specific techniques for training or managing the student on the job site. Academic instruction is individualized and functional in that it relates to the world of work.

Another group of vocational programs developed for the mildly to moderately handicapped includes the center-based vocational training combined with on-the-job training. Features that have been added to accomodate the handicapped student include intensive support or counseling at the work site and specialized training in developing skills such as how to avoid conflict on the job and how to communicate needs appropriately. Several examples of these types of programs are among the federally funded demonstration programs (see Mirkes, 1981).

A final example of an "alternative" program with a career awareness emphasis is an adapted Foxfire model, Project Sense of Pride (Mirkes, 1981). The program is offered for emotionally disturbed students within the public schools and is considered a supplement to the prescribed educational program. Students involved in the classes produce and market their own magazine, which contains interviews with handicapped adults who have made successful life adjustments as well as with employers in a variety of job and career settings.

Vocational and Adult Living

A less intensive type of vocational program is the part-time program that supplements the regular education program. Richmond (1978) described a highly-structured, part-time prevocational program for emotionally disturbed adolescents conducted in an off-campus leased building. Students attended the program for several hours each day and received job skill training in several vocational areas. They also participated in a structured recreation program. A major focus of this program was the development of appropriate social skills, and living skills such as sewing, cooking, and reading the newspaper. All students were enrolled in a regular high school for some portion of the day, but could also receive instruction in functional reading and computation as well as tutoring within the part-time program.

A similar program operated by the Minneapolis Public Schools is the Out of School Youth Program (Mirkes, 1981). Designed for mildly handicapped adolescents who have voluntarily left school, the program provides vocational training as well as assistance in job seeking and job "survival." The program also provides training in adult living skills, such as parenting, and provides basic academic tutoring as well as individual mental health counseling.

Social Skill Training

A second major type of supplemental program that was noted includes the social skill training programs. These programs reflect the increased attention in recent years to the concept of social skills—specifically the direct teaching of behaviors that are considered essential for survival in a regular classroom or job site. The recognition that social behaviors could be effectively taught, much as academic skills are taught, is not new. In fact, a number of procedures for teaching social skills have been demonstrated to be effective (Minkin, Braukman, Minkin, Timbers, Timbers, Fixsen, Phillips, & Wolf, 1976; Werner, Minkin, Minkin, Fixsen, Phillips, & Wolf, 1975; Willner, Braukman, Kirigin, Fixsen, Phillips, & Wolf, 1977).

While the importance of such training was frequently noted by early program developers, only recently have packaged social skill training curricula or programs begun to be developed. Two examples of such programs include Social Effectiveness Training (SET) (Mirkes, 1981) and the Social Behavior Survival (SBS) curriculum (Walker, in press). The SET program teaches 13 specific social behaviors through use of role playing and behavioral rehearsal. The structured program is designed to supplement existing instructional curricula and can be used within the classroom or other settings. The SBS curriculum, also designed for small groups, provides direct instruction of five essential classroom behaviors and 28 peer-to-peer social skills. The teaching procedures involve verbal instruction, modeling through use of video-taped vignettes, and practice role playing.

The curriculum focuses on facilitating the integration of handicapped students into the mainstream.

A somewhat different approach to training socialization and survival skills is being implemented at the Judge Baker Guidance Center in Boston, Massachusetts (Mirkes, 1981). This curriculum addresses a wide range of areas, including problem solving and decision making, social awareness, sexual development, peer relations, drug abuse, "law-related" issues, and career awareness. The instructional approach involves role-playing and problem solving in small group settings.

Absent from this review of recent programs were references to supplemental programs in art, music, dance, and recreation. Of all education programs reviewed, none reported utilizing any of these types of therapeutic interventions. Several cross-categorical programs in adaptive physical education and recreation indicated that they served emotionally disturbed students; however, it was difficult to determine what special adaptations or additional activities were being provided to the mildly handicapped students. Several recreational programs involving Outward Bound or wilderness training and camping and hiking were also noted in the literature. All of these programs, however, were conducted by agencies other than the public schools and were offered as voluntary, extracurricular activities.

This review would be incomplete without a brief mention of the programs located in special public schools. These programs are considered to be for the more severely behavior disordered. This, however, may be an erroneous distinction in the absence of a clear definition of who these programs serve. However, it is probably a fair assumption that only the more mild and, therefore, tolerable student, will be maintained in a regular public school setting.

Special Schools

The segregated public school programs generally operate in special buildings and parallel the regular public school programs. In general, the special public schools appear to be a more frequently used option for the emotionally disturbed adolescent. This, however, may be less a reflection of the specialized needs of these students than the degree of problems their behavior causes within a regular public school.

Three examples of such special schools include the Madison School in Minneapolis (Braaten, 1979); the Woodward School in Massachusetts (Kennedy, Mitchell, Klerman, & Murray, 1976) and the Mark Twain School in Montgomery County, Maryland (Laneve, 1979). While the programs offered within these schools differ somewhat in philosophical approach, they all provide, as part of the total educational program, specialized related services such as counseling or therapy and/or vocational and prevocational training. The schools function as total units, separate from the normal public school environment, and the degree of daily integration with nonhandicapped peers is limited or nonexistent. However, these programs cited all operate as part of a full-service continuum. That is, these schools do not constitute the sole program option for students. Rather, students are placed in these schools until such time as their behavior is manageable within less restrictive environments.

The final category of programs reviewed included those for the behavior disordered preschooler. All of the programs discussed so far have been reported as designed for school age children. While several have been implemented with primary age children, the majority have been targeted for upper elementary age children, preadolescents and adolescents. As PL 94-142 mandates appropriate education for handicapped children and youth ages 3-21, a review of preschool and kindergarten programs is in order.

Preschool/Early Childhood Programs

Early childhood programs began to be developed prior to the passage of PL 94-142, which mandated education for children as young as three years old. Stimulated by federal grant programs such as Head Start and the Handicapped Children's Early Education Program, hundreds of programs were developed, a number of which have been widely replicated. Among these are relatively few that have been developed for behavior disordered children as well as for the mildly to moderately handicapped.

Meisels and Friedland (1978) commented on the lack of services available to the preschool behavior disordered child. They cite several reasons for this, among which is the notion that the child's disordered behavior represents a developmental stage that will be "outgrown." With respect to the identification of these students, specifically the more mildly behavior disordered preschoolers, there are both proponents and opponents. While proponents cite the need for early intervention in order to avoid the cumulative effects of failure, opponents are primarily concerned with the effects of misdiagnosis and subsequent labeling of young children as handicapped. It is not within the scope of this chapter to provide a detailed discussion of these issues or to provide a complete review of early childhood programs. However, there appear to be several general characteristics of early childhood programs that have been developed for the more mildly to moderately handicapped children, including those for the behavior disordered.

First, almost all programs are characterized by strong parent and family involvement, which frequently includes training parents in how to manage their child's behavior as well as in how to stimulate learning. A second feature is the major emphasis placed on language and communication. The programs, some of which have a developmental perspective and some of which take a behavioral or task analytic approach, focus much time and specialized instruction in developing communication competency. A third feature is the way in which social and emotional problems are handled. The programs typically include basic behavior management techniques in parent training as well as in the context of the instructional program. However, serious emotional problems tend to be dealt with by social workers, child psychologists, or child development specialists through family therapy and/or counseling.

These early childhood programs that have been developed specifically for disturbed children have been designed for children with more severe maladaptive behaviors. One example of such a program has been developed by Wood (1972) at the Rutland Center in Athens, Georgia. The program employs what is called Developmental Therapy and has a basic psychoeducational orientation. Children in the program attend regular public school programs on a part-time basis, and spend about two hours a day in the special program at the center. The center staff include mental health and special education personnel and other child development specialists. The program has a strong educational focus and provides training in communication and preacademics as well as in developing socialization and age-appropriate behaviors. For a more complete review of models of early childhood programs, the reader is referred to Evans (1975) and Glasscote and Fishman (1974).

Summary

To make any definitive statements about program development for the emotionally disturbed within the public schools may, in fact, be foolhardy. Certainly when considering a summary, one conclusion did appear unarguable, and that is the fact that the emotionally disturbed are underserved. Substantive evidence exists to suggest that public schools are not providing a full range of program options for the emotionally disturbed. Looking only at the Grosenick and Huntze (1980) and Hirshoren and Heller (1979) data, there is little indication that the concept of least restrictive environment is guiding the development of programs.

Turning to the programs reviewed in this chapter, it would be erroneous to suggest that there has been no program development. In fact, there is a sense of almost frenetic, not be be confused with flexible, development. A variety of programs are described and together would appear to respond to the call for reactive and eclectic programming. It is difficult, however, if not impossible, to determine how each of the described programs fits into a comprehensive service continuum. For example, a program that is described as a self-contained classroom may be only one service option provided to emotionally disturbed students within a district; however, there was only one program that mentioned reintegration of the emotionally disturbed student into the mainstream.

The fact that the programs reviewed were presented as isolated and autonomous units may not be unusual; however, the absence of reported effectiveness data is noteworthy. The vast majority of the programs were simply described and not infrequently touted as "successful," yet in only four instances were any supporting data presented. Even in these instances, the data were limited to measures of short-term effects, and there neither was indication that any follow-up was planned nor did there seem to be any concern for long-term general adjustment.

A further impediment to any summarization is the lack of clearly defined target populations. While the programs purport to serve emotionally disturbed, seriously emotionally disturbed, or behavior disordered, there frequently was no specification of the characteristics or behaviors of the students who are involved in the programs. The general lack of a population description makes it difficult to ascertain who is being served by the public schools and in what setting.

In terms of conceptual models or theoretical approaches, it seems that there are two predominant influences. Clearly, the principles and technology developed out of the behaviorist model are evident in the vast majority of programs. While there were few programs that were characterized by strict applications of the behavioral approach, most descriptions noted use of such techniques as "token economies," "point systems," or "time out." The behavioral influence is also evidenced by the number of programs that include direct academic instruction as their major focus.

Also predominant among the programs is a continuing commitment to "therapeutic" interventions, involving group and individual counseling and psychotherapy. It seems reasonable, however, to conclude that these interventions are designed to support or complement a strong educational program and rarely, if ever, compose the total intervention.

In general, all of the programs appear to reflect a narrow perspective of emotional disturbance. That is, the interventions are heavily child directed and seem to cling to the notion that treatment should address specific deficits, be they social, academic, or intrapsychic. There is little evidence that the ecological perspective is being widely applied.

Recommendations

There appear to be three major or priority needs with respect to program development for the emotionally disturbed. First is the critical need to define the population. As noted throughout the discussion of the literature, the concept of emotional disturbance is vague. There is not specific reference to levels of severity. There is no distinction made between the mild, moderate, and severe forms of emotional disturbance, other than the acknowledgment that the phenomenon of disturbance is characterized by a great deal of variability, requiring a wide range of management options. This inability to distinguish between mild, moderate, and severe emotional disturbance is also markedly apparent throughout the field's literature, which appears to further reinforce the notion that educational policy and procedures have evolved from an inadequate and incomplete concept of the basic population to be served.

A second need is for thorough evaluations of existing programs. There is a need for empirical data that clearly demonstrate the effectiveness of various programs, including curricula, service setting, and support services. Such evaluations must begin to consider the long-term results of programs. Specifically, are effects maintained over time and generalized across environments? Program evaluations must begin to include precise descriptions of the child populations served by the program. Given the aforementioned variability within the category "seriously emotionally disturbed," it is imperative that a program's effectiveness be presented in relation to specific student characteristics or behaviors.

The final need is actually comprised of several. First is the need for comprehensive full-service educational planning for the emotionally disturbed. Consideration should be given to providing program options within a system which allow for structure and restriction as well as for fully integrated service delivery. The options should be defined in terms of specific student behaviors or needs. In addition, given a variety of placement options, an educational policy must be developed that recognizes the variability among these students and allows for changes in placement based on need, not label. Emotionally disturbed students, or for that matter, any handicapped student, should not be faced with the option of "making it" in a special class or one type of program.

With respect to comprehensive educational planning and to measures of overall program effect is the evaluation of the effectiveness of various related services, such as counseling and therapy, in terms of their contribution to educational goals. Such services appear to be frequently provided because of a particular conceptual or theoretical bias and not because they ultimately enhance program effects. Once it is determined what services are supportive of educational programs, then policy makers or administrators can begin to explore more creative and more cost-efficient cooperative arrangements for providing such services.

Finally, the need to reconceptualize emotional disturbance in terms of the environment and the social context in which it occurs is not only apparent, but has perhaps the greatest potential for the development of future intervention models. Keogh (1980) has suggested that the traditional global approaches to children's atypical behavior are no longer tenable, given new theories and constructs which are emerging from the child development research. She argues that all atypical behaviors, including emotional problems, must be viewed in terms of the environment in which they occur. Paul (1977) also has asserted that many children who are considered emotionally disturbed are in reality victims of the interaction between the educational system and their own characteristics. Further, he suggests that this variance should be viewed in terms of cultural and value differences and the ineffective or outdated educational philosophies which govern the public school system. This notion has been seconded by Apter (1977), who recommends that future programs shift away from the focus on the child's disordered behavior and instead attend to the disordered ecosystem in which that child must function, and by Kauffman (1979), who, while addressing the need for a reconceptualization of behavioral deviance, also argues that the individual cannot be viewed in isolation from his or her environment. Referring to the basic tenents of social learning theory, Kauffman's position is that the behavior of the student is a function of a continuous reciprocal interaction between the environment and the student's perceptions of that environment. The implications of all of these perspectives to the provision of special education services for the emotionally disturbed is clear. Intervention cannot occur in isolation from the total environment, neither can programs continue to focus solely on the child and his or her specific behavioral deficits.

There has been progress in the area of education for the emotionally disturbed. The fact that programs have continued to emerge during the past 20 years is indicative that schools are making some response to the emotionally disturbed student. Whether that response is self-serving, representing an attempt to maintain harmony in the system, or is, in fact, a legitimate response to the needs of these students may be arguable. The fact is that programs do exist, but their quality or effectiveness is, to a large degree, unknown. These statements are broad and certainly not new; however, if one overall recommendation can be made, it is to stop scattered, episodic program implementation and to begin to develop system-wide service plans based both on empirical evidence of what works and the precise student needs that are being addressed.

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Pathways to Success: Working With Seriously Emotionally Disturbed Students in a Public School Setting

Ronald S. Laneve

Public Law 94-142 includes "Seriously Emotionally Disturbed" (SED) as one of the legitimate handicapping conditions for which special education services must be provided. It also provides a definition. However, the definition has been a source of controversy and confusion. Volumes have been written about the problem of definition; as this issue affects every component of programming for these students, the problem must be recognized prior to discussing public school programs to serve the SED student. In "Disturbing, disordered or disturbed? Perspectives on the definition of problem behavior in educational settings," Wood and Lakin (1979) state that an adequate description of emotionally disturbed/behavior disordered children and youth is a precondition for effective communication and generalization of research findings. Ballow, Rubin, and Rosen (1977) state that the lack of a clear definition of SED students not only severely limits research and communication, but also the development of programs. The purpose of this chapter is not to resolve the problem of definition. However, the failure to define clearly and describe accurately the students who are to be served not only adversely affects the ability of educators to conduct research and develop programs, but also to communicate about effective programs for this population.

Educators who are working in the schools and classrooms do agree that there are SED students in every school or school system. Estimates of populations of emotionally disturbed range from 3% to as high as 50% of a total school population (Deno, 1978). Frequently the number of SED students is determined by the number of placements available within the school system: for example, a school system with 300 placements available for SED students will identify 300 SED students. Without the protection of a clear and precise definition, the SED students can be "defined out" of a school system. Seriously emotionally disturbed students and students with severe behavior disorders are not a "glamour group" of kids. School systems tend to view them in negative terms and are not anxious to serve them. Frequently, educators do not want to work with these students. This chapter describes the work of a large group of competent, dedicated educators who have worked at the Mark Twain School for the past 12 years.

Mark Twain School is a public day school serving SED students in grades 6 through 12. The school, which opened in 1971, is organized into several different program alternatives. The Middle School serves 75 students in grades 6 through 8. The Senior High School serves 95 students in grades 9 through 12. The Samuel Clemens Learning Center serves 100 students in grades 6 through 12. Students who are placed in the Samuel Clemens Learning Center must have two handicapping conditions, severely emotionally disturbed and learning disabled. The Alternative Education Program serves 45 students, grades 9 through 12. Students who attend classes at Mark Twain Center are mainstreamed into the regular education programs in nearby junior and senior high schools. In addition, Mark Twain has two Satellite Centers that are based in regular high school programs. The Satellite Centers provide intensive support for Mark Twain students during their first year in a regular senior high school program. The Educational Support Center, which is based in a regular school, provides intensive support with the hope that the student can be successful and not be transferred to the Mark Twain School (Figure 1).

The goal of each program is to provide as many alternatives for learning as possible. The majority of students who come to Mark Twain have not been able to succeed in a regular public school program. Although many other regular public school systems will choose to define these students out of the population to be served, the citizens of Montgomery County, Maryland and the Mark Twain staff believe that the public schools must serve SED students, or our society and our students will suffer the consequences for years to come.

The Identification Process

The identification of a SED student usually begins with a classroom teacher's frustration over a student's inability to stay on task, negative response to authority figures, or behavior extremes such as withdrawal or disruption. Individual school staff members spend a great deal of time attempting to manage the behaviors of the student, trying to develop individual programs, meeting with the parents when possible to discuss the

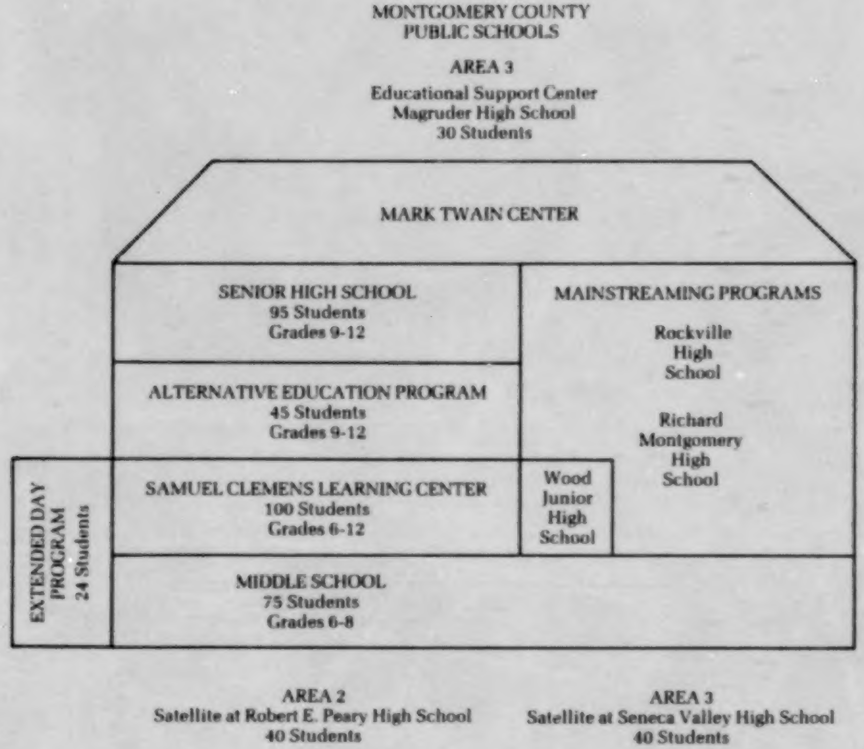

MONTGOMERY COUNTY
PUBLIC SCHOOLS
AREA 3
Educational Support Center
Magruder High School
30 Students
MARK TWAIN CENTER
SENIOR HIGH SCHOOL
95 Students
Grades 9-12
ALTERNATIVE EDUCATION PROGRAM
45 Students
Grades 9-12
SAMUEL CLEMENS LEARNING CENTER
100 Students
Grades 6-12
MIDDLE SCHOOL
75 Students
Grades 6-8
EXTENDED DAY PROGRAM
24 Students
MAINSTREAMING PROGRAMS
Rockville High School
Richard Montgomery High School
Wood Junior High School
AREA 2
Satellite at Robert E. Peary High School
40 Students
AREA 3
Satellite at Seneca Valley High School
40 Students

Figure 1: Mark Twain Programs

student's problems or to suggest home management strategies, or referring the student to the school counselor or similar services.

Eventually, the school staff, and frequently the parents, become so frustrated at their inability to bring about any change in the student's school behavior that the student is referred for psychological testing. The psychological test provides information about the student's ability to learn, and to some degree his or her emotional states. However, the primary source of information used in the psychological evaluation is the school staff. As a result, many students who are learning disabled or general discipline problems are identified as seriously emotionally disturbed and placed in programs designed to serve emotionally disturbed students. The testing process becomes a means to confirm what is already "known" by the school staff—the student is unable to adjust in the school's educational program. The psychologist usually makes some program or intervention recommendations. These usually include placement in a small classroom and a highly structured educational environment. In other words, it is determined that the student cannot be served in a regular school educational program.

Characteristics of SED Students

Each student's case history is unique. Some students experience problems that begin at birth and continue to escalate as they enter and progress through school. Many other SED students do not experience any significant problems until they enter the junior high school environment. In fact, the number of SED students who are identified significantly increases during adolescence, specifically from ages 12 to 16.

Another characteristic in this populaion is gender; many seriously emotionally disturbed students are males. In the Mark Twain School the male/female ratio is 5 to 1. Tuckman and Regan (1971) collected data on about 1,300 children referred to an outpatient psychiatric clinic in Philadelphia. Of the 1,297 children in the study, 67% were boys and 33% were girls (Tuckman, & Regan, 1971). This higher incidence of males has several explanations. However, it is clear that males tend to act out to a greater extent and thus are more likely to be referred out of the public school. Observations by the author made of public school programs serving SED students in several different states confirm that between 75 and 90% of the students are male.

The overriding common characteristic of SED students is lack of success in the regular school environment. Not only do they exhibit problematic behavior, but many could also be appropriately considered learning disabled. Frequently, however, their learning difficulties have never been considered in their educational programs. Many of the students have low to average intelligence, and also are often characterized as having a short attention span. They have difficulty keeping up with the regular school population and need individual attention, including task-specific instructions. Due to the behavior problems, the SED student commonly has a long history of having been in many different school programs. It is not uncommon at Mark Twain to find SED students who have been in eight or nine different schools during the first seven years of their school career. It comes as little surprise that these students typically view themselves as failures and as a consequence have difficulty maintaining friendships or developing good peer relations.

Characteristics of SED Students' Families

If the SED student has certain defining characteristics, he or she still cannot be considered in isolation from his or her family. The family and home environment must be considered as a major factor in developing a student's program. In the author's experience, however, there are few hard conclusions or generalizations that can be made about families of SED students.

The families of students at the Mark Twain School have ranged from rich to poor, educated to uneducated. No one ethnic group is predominant. Some parents have been loving and caring individuals; however, many have a history of physical, including sexual, and "emotional" abuse of their children. According to school and health department records, approximately 30% of the students currently at Mark Twain have histories of neglect or abuse by their parents. A large proportion of these students are adopted or come from single-parent families. Despite these factors, the most significant characteristic of the family appears to be the amount of distress present within the family. This distress may include alcoholism or severe economic problems or a disruption in the marriage. The distress can also be a direct result of the SED child and the impact of his or her problems on the family unit. Regardless of the family dynamics, the result is frequently an abdication of the parent role. One of the most difficult situations to work with is an intact family that appears to support the child but in reality has no interest in the child's educational or personal development. In these instances, parents choose to no longer expend energy on the child or invest in his or her well-being.

In particular, I can cite the case of a 14-year-old girl who was given permission by her parents to live with her 19-year-old boyfriend. The school became involved with the problem because the boyfriend lived outside the county, and the parents were asking that their daughter continue coming to school while living with her boyfriend outside our county. In this case the parents had clearly abdicated their role and had allowed a 19-year-old boyfriend to assume total responsibility for their 14-year-old daughter.

In another example, a student who was living with his mother and father became a victim of the "round robin family" syndrome after his father killed his mother. The student was transferred to live with his sister, then with an uncle, then with the grandparents, and finally to a series of five different foster homes prior to being placed at a detention center.

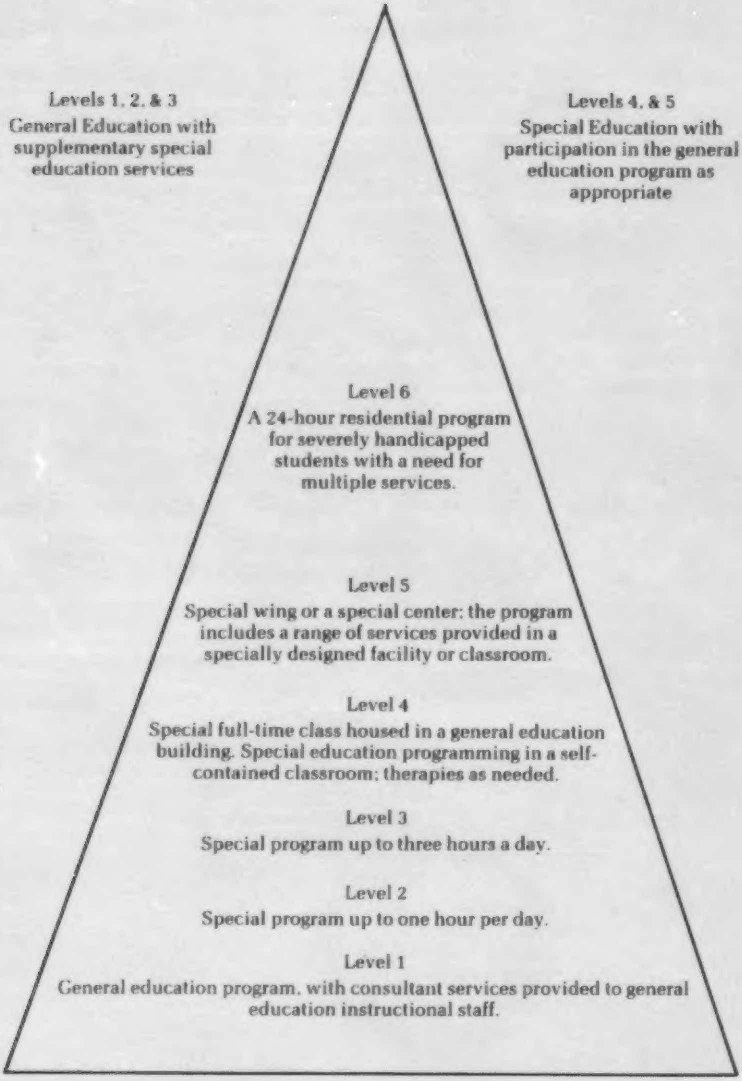
In the identification and placement process the focus is on the child, not the school or the family. As a result, many students are labeled and placed in programs based only on consideration of achievement and classroom behavior. It may be that the student is unable to attain success in a regular school program. In that sense, he or she is fortunate to be identified and placed in a program for SED students which can meet the identified needs. Without the special program, the alternative is for the student to continue to fail, and eventually to drop out of or be expelled from a regular public school program.

Placement

Students are placed at Mark Twain School only after being identified as SED and if they are considered to need a Level 5 service on the Montgomery County Public Schools' (MCPS) Continuum (Figure 2). Montgomery County uses the standard definition of "Seriously Emotionally Disturbed" as contained in PL 94-142. Once a student in Montgomery County, Maryland is identified as SED, the next step is placement in an appropriate educational program. That placement decision is usually the responsibility of an interdisciplinary team; however, many of the individuals on the team have never seen the student. Their individual decisions and the team decision are based primarily on the information provided by the regular school staff and the psychological testing report which, for the most part, is based on information provided by the school staff. The parents are involved in the placement process, but frequently they have information from the school only in the form of reports or complaints about the disruptive or withdrawn behavior of the student. Parents, however, can be one of the best sources of information about any student; they observe the student in environments that are extremely different from school. The parents usually know for certain that the child is not being successful in school. They also know what problems are being faced by the student within the home.

The public educational program designed to meet the needs of SED students must address both the academic and behavioral needs of the students. As the SED student has experienced a cycle of failure in school, he or she will initially resist any attempt to become involved in learning activities. The reaction of an SED student is understandable, as no one likes to fail, and we try to avoid the things in which we fail. Many teachers of SED students have excellent counseling skills, and can design and implement behavior management programs. But if the teacher cannot develop an appropriate individualized instructional program for the student, the student's participation will be limited and will eventually end in failure.

Students who are labeled SED have had numerous problems in school:



Levels 1, 2, & 3
General Education with supplementary special education services

Levels 4, & 5
Special Education with participation in the general education program as appropriate

Level 6
A 24-hour residential program for severely handicapped students with a need for multiple services.

Level 5
Special wing or a special center; the program includes a range of services provided in a specially designed facility or classroom.

Level 4
Special full-time class housed in a general education building. Special education programming in a self-contained classroom; therapies as needed.

Level 3
Special program up to three hours a day.

Level 2
Special program up to one hour per day.

Level 1
General education program, with consultant services provided to general education instructional staff.

Figure 2: The MCPS Continuum

Note: Based on Maryland State Department of Education Special Education Bylaw 13.04.01

problems with teachers, principals, and peers; problems with learning. SED students most frequently act out and are disruptive, but some are withdrawn. The students have a poor self-concept, and the fact that they have been rejected by a public school system confirms their negative feelings about themselves as learners and individuals. Public school programs designed specifically for SED students are painful places for the students to be.

How do we motivate students to demonstrate mature, responsible behaviors? In my experience, simply rewarding a desired behavior and punishing a negative behavior may work for a short period of time, but will not have any lasting effect on the individual's life. The reality of the world (in most cases and over many years) is that as an individual is able to demonstrate consistent, mature, responsible behaviors, greater privileges and freedoms will be available. A public school program serving SED students should be related to the reality of the world in which the student lives. For students who need the reality of a stimulus/response program, the consequences of behaviors should be clear, specific, and consistent. But if the purpose is to help the student grow out of the program and the ultimate goal is to have the student consistently demonstrate mature responsible behavior because that is the way it is "spozed to be," then a basic behavioral program is only the first step. The ultimate goal is to have the student feel good about him- or herself (positive self-concept), and have the desire to do what is right just because it is the right thing to do and because of how the student sees him- or herself; that is, to create within the student an internal set of standards that the student chooses to follow because he or she is a mature, responsible person.

The following diagram (Figure 3) is an oversimplification of the concepts on which the Mark Twain Program is based. At the lowest possible level, where the student is demonstrating immature, irresponsible behavior, a stimulus/response classroom environment is designed for the student. As the student ascends the various levels, moving toward mature, responsible behavior and the ultimate level of self-actualization, freedoms, privileges, and rewards to the student are increased. It is extremely important that resources be concentrated with the students who are working at the lower levels. For example: with students in the lowest possible level, a teacher/advisor (T/A) and an aide may work with five students, while at the self-actualization level a teacher/advisor may work with fifteen students without the assistance of an aide. Another way of saying this is, as the student is able to demonstrate mature, responsible behavior patterns, the resources allocated to provide a program for that student are decreased, while at the same time the freedoms, privileges, and rewards given to the student are increased. Students will move from one level to another, will become fixated at certain levels, or may regress to a lower level. It is important that a program for SED students has a method for becoming aware of changes in student behavior and need, and the flexibility to adjust the student's program as these changes occur. It is also important for the student to realize that he or she has the power to choose behaviors.

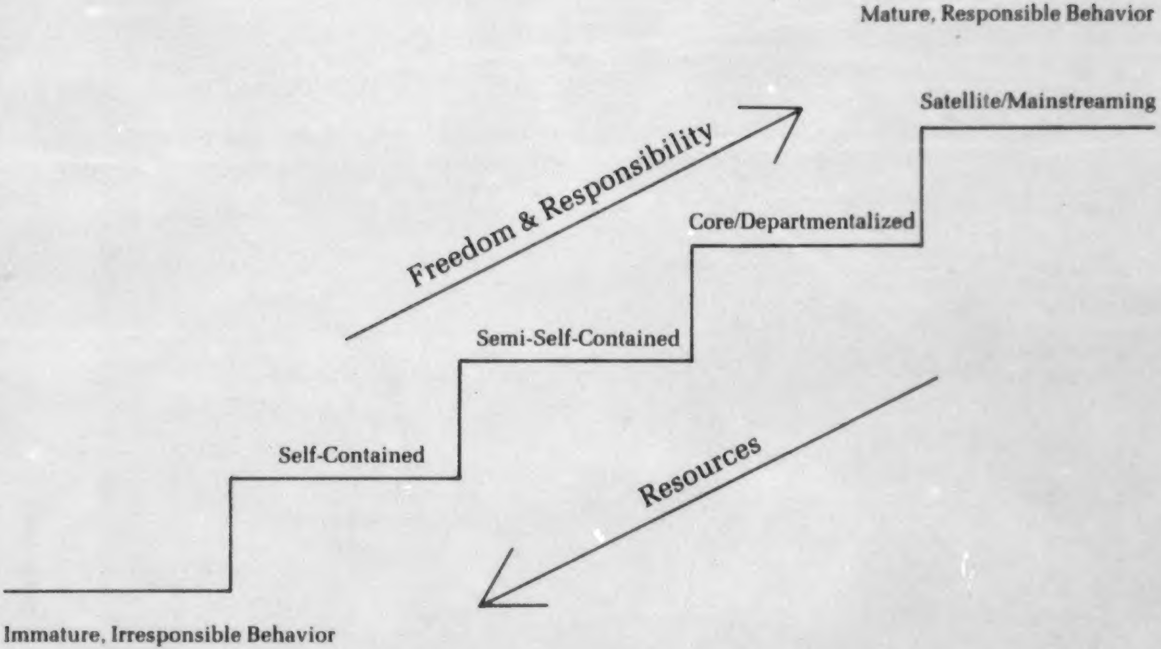

Mature, Responsible Behavior
Satellite/Mainstreaming
Freedom & Responsibility
Core/Departmentalized
Semi-Self-Contained
Self-Contained
Resources
Immature, Irresponsible Behavior

Figure 3: Levels Within the Mark Twain Program

William Glasser, the author of *Reality Therapy: A New Approach to Psychiatry* (1965), states that we all choose our behaviors. Glasser has also stated that many individuals deny the reality that surrounds their lives. Some people deny the reality that if you eat too much you will get fat, or if you drink and drive, you significantly increase your chances of being involved in a tragic accident. These individuals live by the motto, "It will never happen to me." In a recent speech, Glasser asked, "Why does a person stop at a red light?" He used his question to explain that human beings are not mice or pigeons who live in a strictly stimulus/response world. When a human being stops an automobile at a red light, it is because he or she chooses to do so. The person weighs the advantages and disadvantages of stopping or not stopping and then chooses TO TAKE THE ACTIONS THAT STOP THE CAR. Human beings do not stop at red lights because the light is red, they stop because they choose to stop.

SED students choose behaviors that result in their being labeled SED. The task of a public school serving SED students is to devise and implement a program that will help the students see that they have the power to choose, that there are both positive and negative consequences to their choices, and that it is much more fun to be a mature, responsible person with all of the freedoms and privileges than to deny reality or live in a stimulus/response world.

Managing Behaviors

How do you design an educational program that can meet the emotional needs of SED students and address their behavioral deficits? It is important to start with a basic philosophy. Selection of such a philosophy does not exclude the use of workable strategies from other behavior management systems. The basic theory provides a belief and a philosophy for the staff. It is important that the basic theory can be easily understood and implemented by teachers and parents. When other techniques and strategies are used to enhance the basic theory, the messages given to students must be kept clear and consistent.

The basic theory used in the Mark Twain Program is based on the theory and concepts of reality therapy as described by William Glasser (1965, 1969). The basic behavior management system at Mark Twain follows the eight-step reality therapy process:

1. Get personally involved.
2. Deal with present behavior.
3. Help the student place a value judgment on behavior.
4. Develop a plan.
5. Get a commitment.
6. Accept no excuses.

7. **No punishment!**
8. **Never give up.**

A brief description of the meaning of each step follows.

Get Personally Involved

The most important way for a teacher/advisor to "get personally involved" with a SED student is to devote the time and hard work to designing and implementing a motivating and challenging instructional program that is based on the student's needs and interests. It is also important for the teacher/advisor to spend time with the student talking about the student's interests and the problems that he or she experiences in school. Some Mark Twain teacher/advisors maintain contact with students on the weekends and evenings, and frequently provide students with social experiences outside of the school day. The basic message to the student in Step 1 must be: I care about you as a person. Unless Step 1 can be accomplished and a close personal relationship can be developed between student and teacher/advisor, the following steps become meaningless.

Deal With Present Behavior

The past is the past and cannot be changed SED students have had a lot of problems in school and they are experts at rationalizing their behavior. It is extremely important to deal with the student's present behavior and to keep the student focused on *what* happened, not *why* it happened. The SED student knows his or her history of behavior better than anyone else, and although a student may have been fighting with peers since the first grade, when a fight occurs on March 1 in the ninth grade, it is important to deal only with that fight and not even refer to the past. Most of all, don't forget, ask *what* happened, not *why*!!

Help the Student Place a Value Judgment on Behavior

SED students don't have to be told that they shouldn't verbally abuse teacher/advisors or fight. The key to this step is to have the student clearly describe *what* happened. After a discussion of what happened and what the student did, to ask the student to place a value judgment on his or her behavior—a question such as, Do you think that students should have the right to call teacher/advisors whatever names they choose, whenever they want to?—can be asked. We are frequently asked, What if the student feels the behavior was appropriate? Our experience at Mark Twain School has been that in almost every case, if the teacher/advisor has become personally involved with the student and deals only with present behavior, if the behavior is negative and unacceptable, the student will place this value judgment on the behavior. The key here is to have the student place a value judgment on his own behavior. The value judgment cannot come from the teacher/advisor.

The next step is to get the student to consider what is happening to him as a result of his behavior. There is a cycle involving a person's feelings which results in behaviors that others see, which results in reactions to that behavior, which in turn results in creating new and different perceptions or in reinforcing our old feelings about ourselves. This cycle can be explained to the student. As an example, the teacher/advisor may say, OK, you were angry, and when you get angry you fight or call people terrible names. But then what happens to you? Finally, try to get the student to see that changing his or her behavior will in turn result in different reactions from others, and ultimately in the student having different feelings about him- or herself. The Mark Twain staff believe that feelings are extremely important, but more importantly, we believe that we must change behavior, in turn, and the reactions of others to the student's behavior to change his or her feelings about him- or herself.

Develop a Plan

At this point the teacher/advisor has set the stage for new learning. Just telling the student to change his behavior won't work, any more than just telling a person who is drowning to swim will work. Developing "a plan" is the teaching part of the process. At this point it is important to state clearly what the student is to do, and what the teacher can do to help the student achieve the stated objective. It is also important to develop a detailed plan, including what the positive consequences of the new behavior would be, or what the negative consequences of resorting to the old behavior would be. For example, if you get in another fight, you will be suspended, expelled, placed in time-out, and so on. After the plan has been developed, it is possible for the teacher to say to the student, "You are now in the powerful position. You have the power to decide and to choose what will happen to you." It is important to help the SED student see that he or she is the person with the power, and that there are natural and logical consequences to his or her behavior. Figure 4 illustrates a sample case history and worksheet that has been developed at Mark Twain School for designing a plan for Tom Sawyer, a hypothetical student.

Get a Commitment

After the detailed plan has been developed to help the student change his or her negative behavior, or the behavior that is resulting in a problem, the next step is to get a commitment to the plan from the student. At this point it is important to let the student know that making commitments is absolutely necessary in developing mature, responsible behavior patterns. After the plan has been developed, the question to the student must be clear: Are you making a commitment to this plan? If the student nods, don't accept that response. Make the student verbalize the commitment, Yes! I am making a commitment to try to change my behavior.

Accept No Excuses

Unfortunately, helping the SED student change negative behaviors is not as simple as going through Steps 1 through 5. The SED student will often fail to keep commitments outlined in the plan. The plan will be a failure, but it is the plan, not the teacher/advisor or the student, that is failing. Look at Step 8—Never give up! If the student fails, accept no excuses. Don't let the student rationalize why he or she was unable to keep the commitment. SED students are masters at rationalizing their behavior and explaining to the world why they failed to keep a commitment. Don't waste time listening to these rationalizations. Go back to Step 2 and recycle through Steps 2, 3, 4, and 5. Keep trying and never give up.

No Punishment!

Punishment does not work! Punishment will only work as long as the punishment is severe and the student knows that the punishment will be used. In the student's mind, punishment frequently presents an opportunity to display the same behavior for which he or she has been punished. Simply stated, If the student calls the teacher/advisor an obscene name the teacher/advisor slaps the student's face, the behavior may be repeated. Consider the punishment of suspension for students who do not attend school and are truant. As seen by the school, this constitutes punishment. In many cases, the student sees the "punishment" as a reward. SED students who have an intense hatred for school will also resort to extreme negative behaviors, such as fighting, in an attempt to achieve suspension in order to have a legitimate right as a result of the suspension to be out of school. And the punishment used in schools is sometimes ludicrous.

Never Give Up

Never is a long time. It is important to have the student firmly believe that you will, in fact, *never* give up. But what this really means is being able to develop plans and remake commitments one time more than the student thinks you will.

The following ten steps, which have been adapted from Glasser's "Ten Steps to Discipline" illustrate the concept of "Never Give Up":

Step 1: Take time to think and list the ways you respond to the student's behavior. Be honest. If you yell or threaten, list those responses.

Step 2: Ask yourself, are these responses working? The answer is no—or you wouldn't be concerned. Make a commitment not to continue these responses in the future.

Figure 4: Sample/Case History and Worksheet for Developing a Plan for Fictional Student

Student's Long-Range Goal (optional) To graduate from high school—go into the Army

Name: Tom Sawyer DOB: Aug. 9, 1966 Grade: 9

Program: Mark Twain Senior High School T/A Samuel Clemens

Objective—Part B: of IEP—from Pupil Observation Summary Acceptance of Authority

Student/Teacher Discussion Notes: Tom does not see fighting as a problem, his father hit him when he was angry, his sepfather and mother's current boy friend fight a lot. Tom feels being tough is most important, He "hates" school and most of the "f------" teachers"—The women teachers are all bitches and the males are faggs. Tom says "No one can make me stop fighting."

Responsibilities Required to Enable Students to Achieve Objective:

Student

Recognize when he feels like fighting
Seek one of three staff to "talk about it"
Not bump into other students

Staff

Not deal with verbal abuse
Be available to talk about "upsets"
Confront Tom on all physical abuse

Agreed-Upon Strategies:

Tom will practice verbally expressing anger each day
PE teacher will help Tom work out anger on punching bag

Laneve

Consequences:

Positive	Negative
—One hour free time	—One hour less free time
—Two extra smoke breaks next week	—Extended school day
	—Loss of pay phone privilege

Reward/Recognition of Achievement:

Other Staff Involvement: (list name and have initialed) Principal, two assistant principals, all other staff report to principal, and PE teacher

Parental Involvement (if appropriate): Mother agrees to Plan, will increase Tom's weekend free time by one hour if Plan works—also pick up

Data to be Collected: Total number of fights in a week

Fight will be determined by assistant principal (Mr. Thatcher)

Review of Status Through Data Evaluation:

Termination or Development of New Plan:

Commitment: [✓ Yes] No

Student's Signature Tom Sawyer Staff Signature Samuel Clemens

Plan and data to be reviewed on: 10/22/82 Date: 10/14/82

Figure 4 (Continued)
Sample/Case History and Worksheet for Developing a Plan for Fictional Student

TOM SAWYER

Tom is a sixteen-year-old male. Date of Birth: August 9, 1966. Present Height and Weight: 6'2", 200 pounds. Full-Scale IQ Score: 82 with very little scatter on subtest scores.

Tom is a ninth-grade student. He was retained twice, once in the third grade and again in the eighth grade. He wants to go into the Army, but recently found out that the Army will not accept applicants who have not graduated from high school. He has been periodically suspended from school for fighting since the third grade, when his father died after a long illness. In the last two years he has been transferred to three different schools. Reasons given: disruptive fighting—poses a serious threat to other students. The principal at his last school recommended "expulsion" as a result of Tom's instigating a fight between black and white students. Tom was transferred to Mark Twain Senior High School on October 1, 1982. He was involved in three minor conflicts with other students during the first week—two verbal, one physical. During the second week he was involved in two fights with other students.

Tom's mother wants him to graduate from high school and says she is willing to help the teacher/advisor. She feels, however, that the schools are filled with racist Ku Klux Klan members, and refuses to enter the school building. The mother is currently living on welfare and food stamps, and does not have a telephone. Tom's father died when Tom was nine years old. His father was an alcoholic and beat Tom and his mother. Mrs. Sawyer remarried a year later. The second marriage lasted only a year and a half, as the second husband was also a wife beater and an alcoholic. At present Mrs. Sawyer lives with "two uncles."

The most recent psychiatric evaluation states that Tom is a young man in dire straits who exhibits a great deal of aggressive, acting-out behavior. It is difficult to know whether his academic underachieving and presentation of himself as having low average intellectual abilities are a result of his emotional difficulty or the overall poverty and social deprivation he has experienced. Tom's social and moral judgments appear adequate; however, his past behaviors and attitudes suggest that if his immediate needs are in conflict with social or moral obligations, he will disregard the social and moral obligations. This young man comes from an extremely disturbed background. Living currently with his mother and two uncles, his extended family seems to be perennially disintegrated and clearly he has no concerted family support. Tom has been in trouble with the juvenile authorities on many occasions. At no stage during the evaluation was any formal thought disorder noted. He did not appear to be perceptually disturbed nor was there any evidence of delusional thinking. Tom is not psychotic, but is seriously depressed. Recommendation: Residential/educational treatment with attention to academic remediation and increase of impulse control. Without substantial and immediate intervention, the prognosis for this young man and society are, at best, gloomy.

Step 3: Develop a plan to help the student improve his or her behavior. The plan must say, You are special. I care about you. When the student gets the message that you care, he or she may become more angry, hostile, aggressive, and resistant. Remember, you have changed your responses and the knowledge that someone really cares about him or her may result in increased deviant behavior.

Step 4: When the student disrupts, simply say, Please stop it! You have done this before, but usually without having done Step 3.

Step 5: If the student doesn't stop, ask, What are you doing? You may have to say, This is what I see you doing, but it is better to have the student describe his or her behavior. Then ask, Is what you are doing against the rules? Try to get the student to place a value judgment on his or her behavior.

Step 6: If the student does not modify his or her behavior, tell the student that you must have time together to work out a plan that will help him or her follow the rules. Be firm!! But be sure to set time aside to meet privately with the student. When you meet, the plan must contain more than the message—Stop it. The student should be involved in setting up the plan, but you will have to help with ideas, suggestions, and questions.

Step 7: When Steps 1 through 6 are tried and result in no change in behavior, a student must be assigned to a quiet room or quiet space within the classroom. The student must get the message that he or she is no longer involved in the class activities. The student must remain away from the class until an acceptable plan has been worked out to help him or her follow the rules. If the disruptive behavior continues when the student is assigned to the quiet room or quiet space, the student must be excluded from the classroom. The message to the student should be, When we can work out an acceptable plan that will help you follow the rules, you may return.

Step 8: In-school suspension is the next step. Students may be assigned to a time-out room that is away from the instructional area, but there must be a person to work with the student to help develop a plan that will help the student follow the rules. Time out must not be punishment.

Step 9: When a student cannot be maintained in the time-out room, the parents must be required to take the student home. Again, the message is the same, When we can work out a plan that will help you follow the rules, you may return to the classroom and participate, and we want you to participate.

Step 10: When Steps 1 through 9 are repeatedly tried and fail, the student must be placed in a more restrictive educational environment. If a plan is developed that will allow the student to meet agreed-upon behavioral goals, provision should be made for the student to be welcome to return to the school.

Note. Adapted from "Ten steps to discipline" by William Glasser, unpublished manuscript, 1976.

Academic Program

Probably the most common characteristic of all SED students is their failure to attain success in a school environment. A major step in designing educational programs is to get personally involved with the student and provide a successful learning environment. Developing an academic program for SED students is a complex task. The process used must be very simple. A four-step cyclic process works most effectively.

Step 1: Assess the student's present skill level—what can the student do?

Step 2: Design a program for the student which the student has the ability to complete—what is the student to do?

Step 3: Implement the program and help the student get involved in completing the learning activities. Success activities are extremely important.

Step 4: Assess the student's present skill level (same as Step 1).

If the student's skill level has not increased, try again! or recycle. If the student's skill level has increased, move to Step 2 and design instructional activities appropriate to the student's new skill level.

Priorities

The academic program must be based on priorities. In a regular junior high school program, students take classes in English, math, science, social studies, physical education, and the arts. The courses offered to students in a regular comprehensive high school are too numerous to mention. There are many different courses in any of the major subject disciplines. For example, in science there are courses in biology, earth science, physics, chemistry, and so on. In social studies, the alternatives include geography, U.S. history, problems of the twentieth century, and so on.

What are teachers of SED students to do? The teachers cannot be expected to be competent in all of the academic areas, or to meet the needs of students who are frequently working on different grade levels. In addition, these students are frequently resistant to learning activities, and the teacher must develop individualized behavior management programs for the students in addition to developing the academic program.

Any time a task is overwhelming, the importance of setting priorities significantly increases. As attempting to meet the academic needs of SED students is difficult, priorities have been established for the Mark Twain instructional staff. The goal is to develop an academic program that will focus on improving the student's ability in listening, speaking, reading, writing, and mathematics. There is also a need for the students to see that there is an application of the five basic skill areas to real life situations. For example, percentage is not just a mathematical exercise: percentage is and will be used (in most states) every time sales tax is added to a purchase, thereby increasing the cost of the purchase and decreasing the percent of money the student will have left to spend on other things.

If a regular public school curriculum includes U.S. history in the ninth grade, it is important for the student to have some knowledge of U.S. history, but at Mark Twain we believe the priority in the classroom must be on developing the five basic skill areas. In other words, it is much more important for the SED ninth grade student to learn to listen, read, write, and discuss (talk/speak), than it is to memorize history facts. If the teacher can develop an instructional program designed to develop the five basic skill areas which utilizes U.S. history content, it is a bonus. Simply stated, the skills of reading, writing, listening, speaking, and computing are more important than subject content.

Teacher/advisors of SED secondary students also usually have students from several different grade levels in the same class. Many of the students are also learning disabled, or have missed a lot of school because of hospitalization, suspension, or truancy. Establishing basic priorities for the instructional program will make the teacher/advisor's task much easier. If the teacher/advisor cannot include U.S. history facts for ninth grade students, but can develop learning activities that will help the student improve his reading skill, we are working on our established priorities.

Evaluation of Classroom Performance

In an attempt to evaluate what is actually happening in the classroom, the teacher/advisor must ask the following self-assessment questions as a measure of his or her own performance.

1. What can the students do? (Do I appraise student learning levels, interests, needs?)
2. What are the students supposed to be able to do, and can they do it? (Do I establish learning objectives consistent with the appraisal of student needs, requirements of the curriculum, and knowledge of human growth and development?)
3. Are the students doing it? (Do I provide for involvement of students in the learning process?)
4. What am I (the teacher) doing? (Do I plan for and use instructional methods that motivate and enable each student to achieve the learning objectives?)
5. What am I using and what are the students using in the teaching/learning process? (Do I utilize those resources that motivate and enable each student to achieve learning objectives?)
6. How are the students doing? Are they developing new skills? (Do I utilize evaluation techniques that motivate and enable each student to achieve the learning objectives?)
7. What is the classroom environment like—heat, light, sound, atmosphere? (Do I maintain the environment required to motivate and enable each student to achieve the learning objectives?)

8. **How do the students/parents feel about me as a teacher, and how do I feel about the students/parents? (Do I maintain relationships with students and parents which reflect recognition of and respect for every individual?)**

9. **What do I need to do to be a better teacher or to improve the instructional program? (Do I appraise my own effectiveness and demonstrate successful application of skills and information acquired to increase effectiveness?)**

Consideration for Staffing the Educational Program

What has been described so far is applicable to any classroom, or could be used by any teacher; however, it only addresses the classroom program. Developing an educational program for SED students, which includes an appropriate, individualized academic program and an individualized behavior management program, is critical if the student is to have any reasonable chance to be successful in a public school environment. However, a major factor in the success of any educational program is the quality of the professional staff.

Teacher/Advisor

Inherent in the philosophy of the Mark Twain School is that teachers who work with SED students must be master teachers and also function as counselors or therapists. We believe in attempting to develop a "therapeutic" educational environment in which the teachers develop a cooperative, supportive relationship with the student and parents.

At Mark Twain School we have developed a position of teacher/advisor which includes far more than the considerable task of providing a student with an instructional program. The T/As, as we refer to them, are assigned from 6 to 14 students, depending on the severity of the student's emotional disturbance. They meet each day with these students to provide individual or group counseling. In reality therapy these periods are referred to as "class meetings." At Mark Twain we call them T/A Groups. The T/As also provide the students (and frequently the parents) with individual counseling. The Mark Twain T/As are not psychiatrists or psychologists, and many are not certified as school counselors; but in my opinion many of the Mark Twain T/As could be considered highly skilled "therapists."

The teacher/advisors coordinate and disseminate information about the student to staff, parents, and outside agencies. They also consult with the student's therapist, pediatrician, or outside agencies to ensure that the student is provided with necessary support services. All records for the student are maintained by the teacher/advisor. It is the T/A who designs, implements, and modifies the student's educational and behavior management program. The T/A could be called the case manager, teacher, friend, and confidant. If a visitor talks to the students at Mark Twain School, the students are not likely to tell the visitor about the beautiful facility that includes a swimming pool and is fully air conditioned and carpeted. The students won't talk about the computer-based math instructional system. What the Mark Twain students most frequently do talk about is the help and assistance provided to them and their families by their teacher/advisor. As a student recently stated,

> My T/A is the only person that I have felt really understood me. Not only does he understand me, but I feel I can tell him anything about how I am feeling or what I am thinking. My teacher/advisor keeps the important part of what I say and lets the rest of it just fade away.

In an attempt to define their role clearly, the Mark Twain teacher/advisors developed the Teacher/Advisor Roles and Indicators (Table 1). The responsibilities of the T/A are divided into six separate categories. In keeping with the Mark Twain priorities, teaching is the first and most important of the responsibilities of a teacher/advisor. The T/A also provides the student with counseling services and in all situations remain as the student's advocate. This one person constantly strives to see the world through the student's eyes, to experience what the student experiences. The T/A must also develop a cooperative partnership with parents, for he or she must help the parents gain an understanding of the behavior of their child in the school environment and how a consistent home/school program can be developed for the student. In addition to being the teacher, the counselor, the student's advocate, and a parent supporter and trainer, the teacher/advisors have the responsibility for IEP development and record-keeping, and participate in the total Mark Twain School program.

Table 1
Teacher/Advisor Roles and Indicators

Teaching: To provide students with a stimulating, challenging instructional program.

—Appraises student learning levels, interests, and needs.

—Establishes learning objectives consistent with student needs and knowledge of human growth and development.

—Plans and provides for involvement of students in learning process.

—Plans for and uses instructional methods that motivate and enable each student to achieve learning objectives.

—Plans for and utilizes resources and techniques that motivate and enable each student to achieve learning objectives.

—Establishes and maintains an environment required to motivate and enable each student to achieve learning objectives.

—Appraises effectiveness of own teaching practices and instructional program in terms of own instructional objectives and total school's instructional program.

Table 1 (Continued)
Teacher/Advisor Roles and Indicators

Counseling: To provide students with regularly scheduled individual and group counseling experiences.

—Counsels students using appropriate techniques.

—Communicates understanding of feelings.

—Identifies and communicates areas of concern and/or disagreement.

—Gives and receives constructive feedback.

—Counsels with student groups to improve understanding of self and others.

—Leads groups of students in discussions regarding academic, social, and behavior problems.

—Assesses group process and group dynamics.

—Establishes, promotes and supports appropriate group behavior.

—Interacts with groups or students.

—Utilizes appropriate resources and plans activities to help students with separation and termination.

Student Advocate: To be the student's constant advocate in all situations.

—Acts as advocate for student with other staff, parents, and outside agencies.

—Coordinates and disseminates appropriate information to staff, parents, and outside agencies.

—Demonstrates student advocacy by establishing, promoting and supporting appropriate individual and group behavior.

—Consults with therapists, parents, Protective Services, Social Services, Court Diagnostic Team, and other agencies.

—Takes the initiative to contact other staff concerning individual.

—Consults with liaison teachers and assists in the identification of appropriate services for student's needs.

Parent Partnership: To facilitate a cooperative parent partnership.

—Provides parent counseling and parent support.

—Makes home visits or home conferences when necessary.

—Attends evening parent programs as requested.

—Communicates frequently and effectively with parents via telephone or personal contact.

—Conducts conferences with students and parents or guardians to report student's progress.

IEP and Record Keeping: To manage the student's IEP development, implementation, and modification; and to maintain all necessary records.

—Identifies and uses all available data to develop the IEP.

—Assists in the prioritization of individual objectives for students.

Table 1 (Continued)
Teacher/Advisor Roles and Indicators

—Assists in the identification of criteria for attainment of IEP objectives.

—Recommends specific instructional techniques and programs for students.

—Sets up and maintains total behavioral management programs.

—Maintains red notebook.

—Completes academic/behavioral summaries and exit IEPs.

***Participation in Total School Program:** To take an active role in the total school program.*

—Provides crisis support and crisis intervention during planning time.

—Provides supervision during the loading of busses.

—Supervises students during their lunch time.

—Escorts students from Arts Barn.

—Provides coverage when no substitute is available.

—Provides back-up for Time Out or other teachers in program.

—Assumes formal/informal leadership to provide boost to morale; i.e., constructive criticism.

—Participates in staff development activities.

—Participates in school management and shares responsibility for total school program.

Techniques and Strategies

Although the principles of reality therapy guide the basic strategies used at the Mark Twain School, teachers must still attend to a variety of techniques in working with individual SED students. Also, because the problems exhibited by SED students can become overwhelming, the first strategy is to define what the school can change, and not waste valuable time and resources on the things that cannot be changed by the educational system.

Define What You Can Change

What are the limits of change that are possible in the school? If a student has a mother or father who is a prostitute or an alcoholic, or the parents verbally or physically abuse each other or the children, the school cannot be expected to change the home environment. It is important for the school to define what can be changed by the school. The staff of the Mark Twain School have developed a list of the behaviors that they believe they can influence (Table 2). The "change variables," as they are called, encompass many of the problem behaviors of SED students. The change variables are interrelated, but it is important that goals for individual students focus on only one of the change variables at a time.

It is also important that staff select a change variable on which they are likely to have impact. This can also involve breaking the specific variable into the smallest possible steps. For example, if a student has not been attending school, the initial objective is not to have the student attend school. Rather, the beginning objective would be to have the student attend one day per week, or one period per day. Progress made in one area positively affects the other areas. For example, if a plan is developed to help a student increase his or her on-task behavior, other change variables, such as emotional control and response to authority, will also be positively affected.

The change variables have helped Mark Twain staff define what they can change, develop a terminology that is used and understood by all staff members, and develop a system for data collection in the identified problem areas. After developing and using the list of change variables, the staff wanted to define each variable further, so Level Two descriptors were devised. Next a list of behaviors that fit under each Level Two descriptor was developed. The change variables not only serve to define what can be changed, but also help the staff select priority objectives for the IEP, and collect and share data with students and parents at conferences.

Consider All Possible Factors

Public school programs serving SED students must consider at least three factors in addition to the student in developing a total educational plan. These factors are the family, the school environment, and the student's peer group.

Although the school can probably change the family to only a small degree, if at all, the effect of the family on the student must be considered. First, school staff must be sensitive to the needs of the parents of SED students, some of whom have been to hundreds of conferences, losing work time and money and getting few or no positive results. Extra effort must be expended to contact parents and get them involved.

If parents have given up on their child, however, and will not become involved in any way in the educational program, the public school cannot refuse to admit the student or suspend or dismiss him or her from school. Therefore, the school staff are wasting time and perhaps significantly increasing the student's distress by continuing attempts to involve unwilling parents. These attempts may remind the student that his or her parents do not care, and in most cases, time spent attempting to contact these parents would have gone to the student. There is always the chance

Table 2
Mark Twain Change Variables

Pupil Name____________________ Teacher Name____________________

Attendance	Attends school on regular basis. Remains in school all day. Arrives on time and stays in classes.
Classroom Conformity Acceptance of routines and procedures	Brings required materials to class. Follows teacher directions. Does not disrupt class activities. Follows established classroom routines.
Bus Behavior	Does not endanger the safety of self and/or others. Shows respect for drivers/staff. Does not verbally/physically abuse other students.
Task Orientation Persistence with task through mastery.	Works with conventional classroom teacher supervision. Works in an organized manner. Completes tasks in an appropriate amount of time. Completes tasks with acceptability quality.
Sense of Self-Worth Presence of self-confidence, personal security, and high self-esteem.	Shows pride in accomplishments. Accepts praise and encouragement. Protects own rights in a constructive manner. Is willing to take risks.
Self-Responsibility Self-evaluation and acceptance of responsibility for success and failure.	Shows awareness of own strengths and weaknesses. Accepts responsibility and consequences of behavior. Demonstrates independence of behavior.
Emotional Control Appropriate reaction to tension, frustration, and change.	Copes appropriately with frustration. Expresses feelings in a controlled manner. Reacts appropriately to constructive criticism.
Problem-Solving Active engagement in efforts to cope with and solve problems.	Accurately describes own problem situations. Describes appropriate behavior alternatives. Chooses appropriate behavior alternatives.
Acceptance of Authority Presence of trust and amity in attitudes toward those representing authority.	Accepts direction from staff. Does not verbally abuse staff. Complies with school rules and regulations.

Table 2 (Continued)
Mark Twain Change Variables

Respect for Others Acceptance of desirable social standards including rights and property of others.	Does not abuse or encourage abuse of others. Shows regard for the needs and feelings of others. Does not abuse school property.
Social Skills Acceptance of group standards and ability to work effectively with peers.	Is accepted by peers. Shows poise in dealing with peers. Works cooperatively with peers. Does not seek excessive peer attention.

that if the student begins to be successful in school, the parents will become involved in the program.

It is difficult for teachers and administrators to look at the school as a possible source of a student's problem. But no matter how much an individual teacher gets involved with a SED student, or how good the teacher makes the student feel about him- or herself, the instructional program will fail unless it is appropriate for the student; that is, unless he or she experiences success. Programming for academic success is a critical responsibility of the school.

An additional consideration is the relationship between the individual student and his or her teachers. No one can get along with or work with everyone. The personalities of members of any public school staff are extremely different, and their styles vary from that of the strict disciplinarian to that of the counselor. If the mix of student and teacher is not working, it should be changed. Doctors, lawyers, and many other professionals have long recognized that they cannot be successful with all individuals. Public school teachers and administrators must realize that this is true in working with students.

The most important task for teachers is to identify all possible motivators for individual students. If none is apparent, the staff must be creative. For example, recently a student was involved with a great number of problems and his teacher/advisor found him impossible to motivate. By chance, during a brief talk with the student, the teacher/advisor learned that the student's girlfriend was in another school in the district, and the student wanted to be with her. While it was impossible to transfer the student, arrangements were made for him to talk to his girlfriend on the telephone each day during lunch period. The student did not have to do anything to earn the privilege. It was his for the asking. The priviledge of the phone call served as a powerful motivator, however, because the student felt that perhaps the teacher/advisors did care about his needs and desires. While this was the case, the teacher/advisors also managed to create a privilege that could be used in a plan and removed as a consequence for inappropriate behavior.

Teacher/advisors also frequently incorporate behavioral techniques into their classroom strategies. In particular, they develop simple written contracts with students and sometimes with parents. They also use systems whereby students are awarded points for completing work or for following classroom rules. Interestingly, the collective experience of the Mark Twain staff is that back-up reinforcers, to be used in conjunction with points, do not seem to be important factors in the student's compliance. Life Space Interviews (Redl, 1963), may also be used by some staff. These are individual counseling sessions involving a student and his or her teacher/advisor. The purpose is to help students become aware of what is going on in their lives at a particular time and to see how present events may be influencing their problem behavior. Through this counseling the students can learn that they have many of the same problems, fears, and angry feelings that others have. The teacher/advisors can help students understand that it is okay to be angry and learn how to express the anger appropriately. Some teacher/advisors also conduct daily peer counseling groups. These provide students with an opportunity to talk with peers about their problems in school, at home, and in the community. Teacher/advisors at Mark Twain are expected to have the ability to use a variety of specific strategies and techniques which can help the SED student develop appropriate and responsible behavior patterns.

Documentation

If you aren't specific about what a student is working on, you won't know what or how to measure positive or negative changes. What is a SED student's priority objective? Why is the student in a program for seriously emotionally disturbed students? How can the individual's progress or lack of progress be measured?

Several years ago, a consultant was employed to work with the Mark Twain staff. He emphasized three basic points in developing a public school program to serve SED students:

1. Select only one objective to work on at a time.
2. Don't set expectations too high (if you do, failure will soon follow).
3. Define how to measure the progress or lack of progress before you start.

The consultant also indicated that educators are poor at developing and implementing documentation systems. He stated that as a result many educators become frustrated because they cannot recognize progress. He emphasized that the selection of one objective and development of a documentation system would help the student and the staff see where they were going and measure their progress. A behavior documentation form and serious incident form are examples of how individual students' behavioral progress is measured at Mark Twain. In addition to these forms, which are completed as needed, the teacher/advisors rate each student on the Mark Twain change variables each week, which are based on the change variables in Table 2. These weekly ratings are averaged and reported to the parents and students at the reporting conferences that are scheduled at the end of each nine-week period.

The student's priority objective, "The Plan," and all of the other data, are filed in a loose-leaf notebook. There is a separate notebook for each student. These data are used to measure student progress. For example, if a student and a teacher/advisor are working on social skills because the student has been involved in eight or ten fights with other students in a period of six weeks, the area of social skills and improved interaction with peers would be the single objective to be worked on and included in developing a plan. The teacher/advisor would then collect specific information on the behavior documentation form or serious incident form which related to the priority objective. If, six weeks after the priority objective has been established, the student has been involved in only one or two fights with other students and has developed one or two friends within the group, the student, the teacher/advisor, and the parent can see that progress is being made. It should be noted that the behavior documentation form can be used for both positive and negative behavior; that is, to document fights with other students, or help offered to another student as an expression of friendship.

Student Progress

If, when an SED student enters a public school program, he or she is fighting when angry with other students and staff, but six months later the same SED student is calling students and staff obscene names when he or she is angry, that is progress! But, if the staff fail to document the entry behavior, it will be impossible for the staff or the student to see the progress that the student has made. You can be certain that the people who are being called those obscene names (usually in front of many other people) will not feel that this student has made tremendous progress. But a quick look back at the entry behavior could result in the student's and the staff's feeling good about the progress that has been made.

Why do SED students get discouraged and frequently give up? As a student recently told me,

> You school people are all the same. As soon as I make progress and accomplish a goal in one area, you set a new goal. You don't even take time to tell me that I've accomplished the goal we set several weeks ago. When I came to this school, every time I got angry I simply said something and walked out of class and you didn't see me for a day or two until I was ready to come back. We worked on different ways of me being able to handle that anger, and now I remain in class. I haven't walked out of here in six weeks, but all I hear about is the fact that I don't get enough work done in class; I've got to improve my task orientation. When did the staff or anyone around here ever stop to tell me that I had really made some great progress because I was staying in school and not just walking away from problems?

I believe this story helps demonstrate why SED students frequently get discouraged and stop trying to make any behavioral changes. Unfortunately, standardized tests to determine whether or not a student has made behavioral progress do not exist. By and large what do exist are subjective judgments about whether the frequency and intensity of a student's behavior fit within the norm, and the norm will vary depending on the population with which the person making the judgment is used to dealing. For these reasons, tremendous emphasis must be placed on setting a specific objective for students, identifying strategies and learning activities that will help the student attain the objective, and developing a documentation system for the staff and student to measure progress.

Student Progress: Summary

The purpose of this chapter has been to describe the Mark Twain School program and the basic concepts that are used in the Mark Twain program. The fact that SED students do not represent a glamour group of students and that public schools frequently do not have the resources or trained staff available to serve these students make programming for them extremely difficult. The lack of a clear definition and the many complex problems experienced by SED students make educational programming an overwhelming task. It is the belief of the Mark Twain staff that any public school program designed to serve SED students must have as a goal helping students develop mature, responsible behaviors, and accepting the consequences of the decisions they choose to make.

A recent study has indicated that 75% of the students who complete the Mark Twain program and are recommended by the staff for return to a regular school program are successful. Success was determined as a result of the students attending school regularly, achieving at least passing grades, and not being seen as a significant "problem" by the principal or counselors.

The Mark Twain program has not found "the answer" to serving SED students in a public school program. However, Mark Twain staff believe that the utilization of reality therapy and many of the materials developed and used at Mark Twain School can be combined to help SED students identify specific goals and achieve those goals. A student who graduated from regular high school wrote as his final English assignment, "What Mark Twain Meant in My Life." The article emphasized how Mark Twain had helped the student assume responsibility for his behavior, and modify that behavior to achieve goals that he considered important. The final paragraph includes the following statement: "Mark Twain helped me 100 percent. It helped me to understand that I was not the only person in the world with problems, and that I could develop into a mature, responsible person."

It would be nice if this same positive ending could be achieved by all students. However, Mark Twain School has also served students who have not been able to attain success, students who have committed atrocious acts, inflicting pain on innocent individuals, and students who have found their lives so full of despair that they have chosen to end their own lives.

The Mark Twain staff believe that the work that we are doing is the most important work that can be done in the world. We have not found the answer for every seriously emotionally disturbed student, but we will not stop searching for the answers for the children we serve. We have learned that there is no one program that will meet the needs of all students, but we believe that if a wide range of educational alternatives can be developed, and if the staff can adopt that one concept in reality therapy, "Never give up," success is possible.

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Service Delivery Teams: Definition, Processes, and Accountability

Linda McCormick

Properly designed interagency agreements require analysis of common goals across agencies, and consensus as to alternatives for meeting shared responsibilities through cooperative efforts. Historically, these agreements were aspired to by many professionals, but seldom attained. There was some "paper cooperation," which gave the appearance of interagency collaboration, but few of these documents resulted in actual partnerships. Developments at the national and state levels in statutory, judicial, fiscal, and policy areas have now established a mandatory base for interagency planning. The related services requirement of Public Law 94-142 (U.S. Department of Education, 1979), and subsequent guidelines (U.S. Department of Education, 1980) require state and local education agencies to seek formal agreements with other agencies to assist in the provision of educational services to handicapped children. Some states have negotiated complex interagency agreements with as many as six agencies, including, but not limited to, social welfare, legal-judicial-correctional, and medical-mental health resources, in order to arrange appropriate services for severely emotionally disturbed (SED) students (U.S. Department of Health, Education, & Welfare, 1979).

Despite numerous problems, mandated interagency collaboration at the state level is generally serving the purpose for which it was intended: available resources are being amalgamated to expand the service capabilities of state education departments. At the local level, however, where state interagency agreements must be translated into practice, problems continue. Certainly it is not that collaboration across disciplines is not recognized as an essential element of service delivery. This paragraph, from an article on recent trends in the education of children labeled behaviorally disordered (Stainback & Stainback, 1980), is evidence of the general acceptance of team decision making as a "given":

> The procedure that is replacing the traditional diagnostic/labelling model involves a straightforward "direct assessment and intervention" strategy . . . It involves the assessment of a child's behaviors (e.g., academic, social, emotional, physical) in the natural setting in which he typically interacts. This usually is done by a team of professionals from various disciplines . . . Once the assessment is completed, the team's analysis of the child's behavior is used to build a program based on the child's needs (considering his functioning level, chronological age and the requirements of the environment he is and will likely be living in). (pp. 243-244)

Problems at the local level derive from the fact that most professionals have had little experience with "teaming." The literature is not much help. It is replete with references to what teams do, but *how* these critical responsibilities are to be discharged has been virtually ignored.

One reason that productive team relationships are so difficult to establish at the district and school levels is the diversity within and across public and private service providers. Each human service discipline representative has different biases and different operating principles. Probably most detrimental, when it comes to agreeing on intervention strategies, is the fact that each professional also has different ideas regarding etiology and intervention. In the uncommon event that there is professional consensus as to classification and intervention goals for the problems of a particular student, there is little or no consensus on how to approach the goals or assign responsibility.

Inadequate preparation for coping with the dynamics of team functioning also affects cooperation and collaboration among the various service delivery options within the school and/or district. In compliance with the law, which requires a continuum of services, public schools in most states provide *at least* the following service delivery options (Huntze & Grosenick, 1980):

1. Itinerant services,
2. Resource rooms,
3. Self-contained classes,
4. Special schools,
5. Out-of-district nonresidential placement,
6. Out-of-district residential placement,
7. Consultant teachers, and
8. Homebound instruction.

Upward mobility toward the regular classroom is the goal for every student. However, unless there is cooperation and collaboration among those responsible for the various service options, each is a closed system.

To say that professional collaboration *equals* improved and/or more comprehensive services for SED students might be an overstatement; however, transdisciplinary actions will certainly have a significant impact on both the quality *and* quantity of services. Difficulties in team functioning at the local level may partially account for this significant disparity between prevalence figures and the number of SED students presently being served. The official federal guess is that 2% of students show behavior patterns severe enough to justify special education and related services (Kauffman, 1981). Recent data indicate that less than 1% of these SED students are being served under PL 94-142 and PL 89-313 (Office of Special Education and Rehabilitative Services, 1980-81).

Perspectives on Team Functioning

PL 94-142 requires four types of working groups, or teams, one to coordinate and monitor all service procedures related to the law, another to make evaluation and eligibility decisions, another to make placement and Individualized Education Program (IEP) decisions, and another to provide the needed special services. (The latter two may have the same composition, depending upon the circumstances.)

Table 1 is a summary chart of the four types of teams with goals, composition, and responsibilities for each group as specified by PL 94-142. One of the responsibilities of SEAs and LEAs is seeing that all four types of teams are created and functional. What is lacking are guidelines for team processes. There seems to have been an assumption by the framers of the law that educators and related services personnel would be capable of working out the communication and logistic problems inherent in working group interactions. Review of the literature suggests that this may have been a brash supposition.

History of Team Functioning

Historically, there appears to be little precedence for team cooperation and collaboration, particularly when professionals from different disciplines are involved. Even health care systems, which have been grappling with team approaches to service delivery for some 40 years, report little success in arriving at satisfactory resolution of team functioning issues (Cherkasky, 1979; Kindig, 1975; Silver, 1973). In 1975, Kindig confirmed an earlier statement by Leninger (1971) that interprofessional competition, stresses, and "one-upmanship" tendencies among health disciplines continue as major threats to effective health care delivery. There are extremely few reports of successful interdisciplinary health teams in the medical literature.

Teams designed for the specific purpose of assessing children with developmental disabilities appeared on the scene in the early fifties (Hormuth, 1957). While the trend toward using developmental disability teams lost

Table 1: Team Responsibilities as Delineated in PL 94-142

TEAM	GOALS	COMPOSITION	RESPONSIBILITIES
Special education committee	*Coordination of all procedures from referral to IEP review* *Monitoring IEP development and implementation*	Permanent members — LEA special education personnel and principals Changing members — relevant professionals concerned with a particular child	Organization of services Appointment of evaluation and IEP teams Assurance of PL 94-142 compliance . Reviewing referrals Assurance that parental rights are protected Authorizing evaluation Monitoring programming
Evaluation team	*Nondiscriminatory evaluation for eligibility determination and program planning*	Membership depends on severity and complexity of suspected disability Team must include at least one teacher or other specialist with expertise in the area of child's disability All members must have certification and/or license appropriate to their area of expertise	Selection and administration of appropriate formal and informal assessments Collecting and reviewing data from other souces Documentation of any potentially biasing factors Interpretation and reporting of evaluation data Serving on IEP team if requested
EP committee	*Development of the IEP*	Child's teacher (special and/or regular) Special education supervisory personnel Child's parents Child (if appropriate) Member of the evaluation team (or person able to interpret the evaluation data) Other relevant professionals (as appropriate)	Review of evaluation data and other information Development of a total service plan (IEP) which includes: —statement of present performance levels —annual goals and short-term objectives —statement of special education and related service needs —projected date for initiation and termination of services —appropriate objective evaluation criteria and evaluation schedule —statement of the extent to which child will participate in regular education Approval of IEP revisions (if required)
Service team	*Implementation of IEP goals and objectives*	Teacher (special and/or regular) Representative of each related service required to assist child to benefit from special education Examples: speech pathology and audiology psychological services physical therapy occupational therapy counseling and guidance medical diagnosis social work	Comprehensive planning and coordination of services Provision of instructional, management and therapy programs Monitoring of instruction, management and therapy programs Parent and paraprofessional training and coordination Mobulization of community resources Planning and programming for transition to less restrictive environments

some momentum in the late sixties, there is evidence (Allen, Holm, & Schiefelbusch, 1978) that it has again become popular. Unfortunately, assessment continues to be the primary focus of developmental disability teams, and most teams are active in nonschool settings. Therefore, this literature is of little more value than the health care literature when it comes to providing practical guidelines for school service delivery team functioning.

The use of "expert" consultants from other disciplines (usually psychology and/or psychiatry) in programs serving emotionally disturbed children can be traced at least as far back as the 1960s. All of the intervention models developed in the sixties—psychoeducational (Morse, 1965), ecological (Hobbs, 1965, 1966), psychoanalytic (Berkowitz & Rothman, 1967; Rothman & Berkowitz, 1967), and behavioral (Haring & Phillips, 1962; Haring & Whelan, 1965)—made some provision for specialist consultation. However, there is some question as to the usefulness of past experiences with specialist consultation because consultation and team functioning are not identical processes.

Caplan (1970) describes consultation as

> . . . a process of interaction between two professional persons—the consultant and the consultee, who invokes the consultant's help in regard to a current work problem with which he is having some difficulty and which he has decided is within the other's area of specialized competence. (p. 19)

While there are many definitions of consultation, they all have a common thread. All define consultation as help offered to another which enables the recipient to perform more effectively and efficiently. Two words, "interaction" and "help," are central to all of these definitions, and these terms also appear in descriptions of what is called the transdisciplinary team process (Hutchison, 1974). Team processes, however, involve substantially more sharing and a greater accountability than the consultant-consultee relationship.

One special education approach that *was* conceived as a team service model was the Re-Ed program, begun in Tennessee and North Carolina in the late sixties. It is interesting to compare team characteristics in this residential service model with those of the more recent transdisciplinary teams operating in public schools.

Briefly, the Re-Ed residential schools exemplify the ecological approach as initially conceptualized by Hobbs (1965). All Re-Ed schools have a number of service delivery teams. Each team is comprised of three special educators, called teacher-counselors, who are responsible for 8 to 12 students. Specialty teacher-counselors, including an educational diagnostician, a physical education teacher, and an arts and crafts teacher, coordinate their activities with the team's goals for each child. Supervisory personnel are ex-officio members of the team, and consultants (e.g., pediatrician, psychologist, social worker) are available for special problems in their respective areas. Suggestions from these outside specialists are just that—suggestions. The team is free to accept or reject them.

Re-Ed teams are defined by the following characteristics:

1. *Common terminology*. One of the basic tenets of the Re-Ed program is avoidance of jargon and discipline-specific terms. Communication problems are rare because team members share the same knowledge base, intervention skills, and discipline affiliation. (Personnel to staff the first two projects were even trained together in a preservice program at George Peabody College.)
2. *Clearly defined roles and responsibilities*. From the beginning of the program in the late sixties, teacher-counselor roles and responsibilities have been clearly defined. Some flexibility and expansion of the various roles is possible, but accountability, sphere of influence, and role expectations are unambiguous.
3. *Frequent routine interactions*. The schedule of activities in the Re-Ed schools provides for daily team meetings—usually in the afternoon when both day and night teacher-counselors are present and the students are participating in such activities as physical education or arts and crafts. These frequent and regular meetings permit continuous monitoring of each child's progress and problems. They also ensure consistent application, across team members, of management techniques. There is every reason to assume that much of the success of the Re-Ed programs in bringing about positive behavior change (Weinstein, 1968, 1974) is, to a large extent, directly attributable to the effectiveness of the service teams.

McGothlin (1981) recently described a school-based team approach with the three characteristics of the successful Re-Ed team. Members are provided with a special training program designed to define team roles and to provide practice in group dynamics and communication strategies. Each team, comprised of representatives from special and regular education, the school administration, and ancillary personnel, meets on a regular basis to assist teachers in pinpointing problems and designing, implementing, and evaluating interventions for students with learning and behavior problems who are in the regular classroom. Although there is no indication that those responsible for designing this approach considered the Re-Ed team model, it appears that the developers of this program have set up the conditions necessary (if not sufficient) for effective team functioning—communication skills, clearly defined roles and responsibilities, and regularly scheduled interactions. The next section will address these requisites for effective team functioning—communication skills and clearly defined roles and responsibilities. To set a context for this discussion, we will begin with a brief description of how the transdisciplinary team approach is *supposed* to work and some of the problems when it is not implemented properly.

Transdisciplinary Team Process

Hutchison (1974) summarized the transdisciplinary process as one in which the members embark upon a conscious effort to:

1. Expand their knowledge and skills through planned team instruction procedures,
2. Allocate functions evenly among team members and eliminate duplication of effort,
3. Share information and skills so that all members will acquire a common core of critical competencies,
4. Release some functions to other team members and parents when an ability to carry them out safely and effectively is demonstrated, and
5. Develop each member's program development and implementation skills.

The key characteristics of the transdisciplinary process, according to Lyon and Lyon (1980), are 1) joint functioning (performing the various aspects of service delivery together), 2) commitment to staff development (maximizing individual team members' strengths and expertise to the benefit of the team and the student), and 3) role release (sharing of information and performance competencies among team members). Consultation-type exchanges may be one element of the transdisciplinary process, but they do not define it. Also, in the transdisciplinary team process, each member is accountable for application of the best practices of the discipline; a consultant rarely assumes this level of accountability.

Transdisciplinary team composition, tasks, and specific objectives vary with the individual team. However, most service delivery efforts have a common mission—preparation of students for transition to and maintenance in least restrictive environments. Associated with this primary mission are preparation and support of mainstream environments to manage and enhance the student's educational and social independence. The role of related service personnel in these efforts is twofold: to deliver appropriate direct services when indicated, and to effect necessary and innovative changes in programming through indirect service functions such as consultation, parent counseling, and inservice education. The problem is how to "get it all together" in order to maximize the impact of available resources on educational opportunities for handicapped students.

Team Functioning Problems

Most articles dealing with team functioning suggest solutions for the array of problems they enumerate. The problem with the solutions is the assumption that professionals are ready and able to embrace team service constructs. The solutions to team functioning problems assume a cadre of professionals who understand and are able to apply communication procedures, decision-making strategies, role negotiation, and conflict management techniques to problem solving. Special education teachers, the team leaders, are assumed to have knowledge and experiences in applying leadership principles, management procedures, and group process strategies.

The transdisciplinary approach may appear straightforward and reasonable; however, inspection of the literature suggests that this is not the case. The special education literature is replete with reports of team functioning problems (Brassell & Dunst, 1978; Fenton, Yoshida, Maxwell, & Kauffman, 1979; McCormick & Goldman, 1979; Sears, 1981; Yoshida, Fenton, Maxwell, & Kauffman, 1979a, 1979b). Most reports do not deal specifically with providing services to SED students, but the problems of teams serving SED students are not any different than those of severely/profoundly handicapped teams. Their most frequently identified team functioning difficulties include:

1. Disagreements related to planning, implementation, and interpretation of assessment results.
2. Inability to accept and explore programming suggestions from team members with different professional backgrounds.
3. Difficulties arising from actual and/or perceived status differences among team members.
4. Disagreements about the apportionment of time in team meetings and in programming.
5. Inability to share general knowledge, informational skills, and performance competencies.
6. Tendency of team members to view the child as a collection of multiple unrelated problems, rather than a single problem complex.
7. Lack of flexibility in adapting to different professional orientations, techniques, and physical settings restrictions.
8. Use of professional jargon specific to a particular discipline.
9. Disagreements on resource allocation and service priorities.
10. Lack of commitment to, and training for, maximizing instructional time.
11. Lack of strong leadership.
12. Lack of training in consultation skills.
13. Personal and professional insecurity.
14. Role ambiguity and lack of skill in negotiating role responsibilities.
15. Preservice training that exaggerates the differences between disciplines rather than emphasizing complementary and collaborative services.

Adaptation to new ideas is never easy, but it is particularly problematic when new skills are involved. Because special education preservice programs (and professional preparation programs in related disciplines) have tended to focus on narrow assessment and remediation functions, many service delivery teams do not include professionals who have had exposure to concepts and techniques associated with group dynamics and the development and maintenance of groups. The result is that problems across disciplines, such as arbitrary and cumbersome jurisdictional boundaries and counterproductive communication, multiply until they preclude any type of collaborative efforts.

It is ironic, indeed, that the very conditions that constitute the strength of a team of professionals from different disciplines—their diverse backgrounds and competencies—are also major contributors to their problems. Add to this the strain of discipline overlap, in both assessment and intervention skills, and the potential for no one to feel personally and professionally accountable, and it is not difficult to understand why school service delivery teams are not as effective as they could be in translating state interagency agreements into practice.

If the team processes essential for effecting efficient and effective assessment, programming, and program evaluation are to be mobilized, there is a need for team members to recognize and offset the effects of:

—Different philosophies, assumptions, and accumulated knowledge about what constitutes deviant behavior and how it should be treated,

—Discipline affiliations that have the potential to overshadow team affiliations, and

—Defensive behavior patterns to control or alleviate threat to either of the above conditions.

The tenets and technology of management and organizational theories provide some guidance; business and management schools have been dealing with work team development and functioning for some time (French, Kay, & Myer, 1965). Unlike the human services field, where team organization and effective collaboration are often perceived and presented in the abstract, change in product-oriented endeavors must be backed up with reliable and concrete production data. Businesses either produce or they fail and withdraw from the competition.

The goal of the next section will be to generalize procedures traditionally associated with business management and group dynamics to the development and maintenance of SED service delivery teams. Guidelines for team organization and service delivery will be presented, followed by an example of how they have been operationalized by one SED transdisciplinary team.

Team Processes and Products

Any athletic coach will readily admit that the motley collection of prospective players assembled on the first day of practice is not a team. The group will not be a team until there is evidence that they can work together toward a shared goal. In addition to a strong commitment, the building of a team requires considerable time and effort. The first order of business for a group of individuals who aspire to become a team is to clarify the original and basic reasons for their assemblage, and to agree on roles and responsibilities for each participant.

Team Organization Processes. There are three organizational processes that teachers and related service personnel should undertake prior to considering student assessment, curriculum planning, service delivery, and program evaluation issues. The first two processes focus on content issues—identifying team goals and objectives, and agreeing on individual roles and responsibilities. The third process considers ground rules for operating: *how* the group will go about achieving its goals and objectives. Satisfactory resolution of these issues may require two or three meetings when the team is first organizing, but it is time well spent. Through these processes each participant learns something about each of the other's background, problems, points of view, and competencies. The group will be well on the way to becoming a working team when these processes have been completed.

Team Goals and Objectives. The group's first task is to agree on goals and objectives. One of the most prevalent mistakes potential work teams make is taking goal consensus for granted (Plovnick, Fry, & Rubin, 1975). Members assume common goals and agreed-upon objectives, so they never explicitly question or state them. Formal clarification of the team's primary goals and performance objectives is imperative. One way to save time is to ask members to formulate a list of team goals and objectives prior to the first meeting (or between first and second meetings). At the team meeting, all goal statements may be written on the chalk board (or a newsprint pad), discussed one by one, and agreed upon or rejected.

Many goals will be common across teams. As noted earlier in this paper, most SED service delivery teams espouse, as their primary mission, the preparation of students for transition to and maintenance in least restrictive environments. Other commonly stated goals relate to individualization of instruction, strengthening school/home/community interactions, maximum use of instructional time, effective teaching techniques, functional skill development, preparation of mainstream environments, and assessment and intervention procedures. In addition to these catholic goals there will be some specific goals that relate to characteristics of the team's target population, such as age and severity, and to existing resources in the school and community.

The next task is to develop and reach consensus on a set of measurable objectives. The following objectives were developed by an SED service delivery team with an ecological/behavioral orientation. Note that at this point in the process professional responsibilities have not yet been assigned.

1. To include at least two representatives of a student's ecology (parents, teacher, welfare caseworker, etc.) when planning environmental manipulations for classroom and/or social behaviors identified as disturbing.

2. To review (and revise, if necessary) each SED student's IEP goals and objectives to assure that they are appropriate and valid and that they reflect ecological considerations.
3. To analyze the various behavior settings in which each student functions and to determine stimulus modifications that will increase the probability of appropriate and adaptive behavior.
4. To develop (for each student) at least one contract with parents or community agency representatives to support age-appropriate after-school and weekend activities.
5. To develop and implement a token reinforcement system.
6. To develop procedures for and implement daily, open-ended class meetings to increase thinking skills and encourage students to relate what they know to new topics.

When the list is complete, each member should have a copy so that he or she can decide service priorities (Kolb, Rubin, & McIntyre, 1979). One way to approach this task is to ask members to rate each objective as a 1, 2, or 3, with 1 being the highest service priority. There will be some disagreements as to the rating, but by the same token, there will undoubtedly be immediate agreement as to the relative standing of many of the objectives. Agreed-upon objectives should be separated out and the status of the others negotiated.

Taken together, the goal statements and the final list of prioritized objectives constitute a type of team contract. This contract may be shared with interested administrators and colleagues, but it is primarily a team document to facilitate ongoing planning, management, and monitoring. As such, it is subject to continuous revision and expansion as the team develops.

Individual Roles and Responsibilities. After consensus has been reached on goals and objectives, the team should begin the second content process—delineation of individual roles and responsibilities. As discussed earlier in the chapter, each professional brings different skills, goals, biases, motives, and expectations to the service delivery setting. Each also brings a range of different sets of roles and a host of defenses to protect against loss of activities or "role functions" associated with his or her set of professional roles. For example, the professional roles of the school psychologist may include evaluator, counselor, behavior analyst, consultant, parent trainer, and team member. The roles of the special educator may include curriculum developer, assessor, classroom manager, team leader, and decision-maker.

The two types of role issues likely to be most problematic are role ambiguity and role conflict (French, Kay, & Myer, 1965). Role ambiguity exists when team members are not sure about what they expect of themselves and/or what they think others should be doing.

Role conflict is usually an effect of inconsistent role expectations (Bradford, Stock, & Horwitz, 1953). There are basically three types of role conflict. The first type, conflict between self and others, comes about because a team member sees his or her role functions differently from the way others see them. The speech/language clinician, for example, may see one of his or her role functions as providing sign language instruction twice weekly for one of the nonspeech children in the class. Others on the team may consider this type of direct instruction to be a teacher role function, and may view the speech/language clinician's roles as limited to assessment, program planning and monitoring, consultation, and teacher and parent training.

Another type of role conflict comes about when two or more team members make inconsistent demands on a third member. For example, the school psychologist may find that one teacher wants only information about, and consultation relative to, self-control procedures for the classroom, while another requests both identification and implementation of these procedures.

A third type of role conflict is called "role overload." Expectations and demands are not in conflict, but they are perceived as unrealistic. Because ancillary personnel are usually members of a number of teams (in the same school and/or in different schools) they may find themselves without sufficient time to fulfill their agreed-upon service functions.

The only solution to these role issues is negotiation—communication and mutual sharing among team members of what they may view as their role functions and the expectations they hold for others on the team (Takamura, Bermosk, & Stringfellow, 1979). Many times professionals are unclear themselves as to their roles *and* their expectations, and extremely uncomfortable with admitting this ambiguity, so the role negotiation process should be introduced in as sensitive a manner as possible.

One approach to role negotiations, which minimizes the potential threat and discomfort in this process, is to use "role messages" (Takamura et al., 1979). The steps in this process are:

1. Introduce the role message process with a brief discussion of the importance of clarifying role functions so that there can be maximum utilization of the information and performance competencies of each member.
2. Provide team members with preprinted role message forms or write the following on a chalkboard, for members to copy:

TO: ____

FROM: ____

I find these services very helpful.
Please do *more* of this:

I need these services. Please *continue* or *initiate* this:

I feel I can manage with less of this:

I would like you to assess my performance of these functions and help me improve:

I consider the following as my specific roles and responsibilities:

I would be comfortable releasing these role functions:

3. Ask team members to prepare a role message for each of the other members.
4. Ask team members to talk with each of their message senders individually during the next week, to clarify their respective messages and agree as to the role functions they will assume and those they will release to one or more of the other team members (with or without training).
5. When the team meets again, combine the lists into one master list of role functions. When the master list has been compiled, the team should share any concerns they may have about the distribution of functions. (If problems arise during this discussion, it may be a good time to introduce the Johari Window described later.)
6. Determine areas where information/skill sharing needs coincide so that future inservice training sessions can be scheduled.

Team Operating Procedures. The third task, after goals, objectives, and role functions have been clarified, is to decide on team operating procedures. Procedural issues include communication strategies and decision-making procedures.

Communication problems are among the easiest team functioning problems to recognize and the most difficult to address. One of the reasons that communication problems are so difficult to resolve may be the many misconceptions and unrealistic expectations associated with the communication process (Hurt, Scott, & McCroskey, 1978). Communication is important, but it is *not* a universal panacea. Very often the communication breakdown that team members complain about as an obstacle to effective cooperation and collaboration is not really a communication problem as much as a symptom of more basic difficulties. These difficulties may be related to differences in perceptions, competencies, role functions, and how the respective team members view themselves and one another. This is one reason for the role negotiation process described earlier. Referring back to the earlier listing of team functioning problems, it is not difficult to see that the vast majority of these problems derive from lack of trust in self and others (which is a significant barrier to mutual sharing and role release) and lack of feedback (which impedes the communication process).

One method the team leader may use to focus attention on variables related to interpersonal perceptions and team communication process is the Johari Window. This model, conceptualized by Joseph Luft and Harry Ingram (Luft, 1969), affords a way of looking at role release, team sharing, and communication processes. (Luft's original model was created to represent an individual's relation to other people.) The point made with the Johari Window is that the team does not necessarily see an individual member as the member views him- or herself. While there are obviously areas of overlap, there are also significant blind spots and hidden areas, which must be recognized and reduced if effective communication is to develop.

If properly presented, the Johari Window model can provide a way of conceptualizing team interactions and exchanges and a reference for continuing dialogue about propensities to think and behave in certain ways. The four-celled Johari Window (Figure 1) may be drawn on a chalkboard or large newsprint pad. The large square represents the context of the team interactions, and the cells depict different types of relationships between a team member and the rest of the team. Each relationship has potential consequences for communication and collaboration among team members.

	Known to Self	Not Known to Self
Known to Other Team Members	I Open Area	II Blind Area
Not Known to Other Team Members	III Hidden Area	IV Unknown Area

Figure 1: Johari Window

Cell I represents knowledge and role functions the individual perceives him- or herself as having—some of which may be shared with others on the team (e.g., knowledge about community resources, behavioral contracting skills). It also includes certain biases that are recognized by both the individual and the others on the team—a behavioral intervention bias, for example. As these personal and theoretical biases are recognized and acknowledged by all, they are not significant obstacles to communication. In fact, this cell is the maximum communication area. The larger Cell I is or becomes (the more mutually held perceptions there are), the more effective communication becomes. Rather than ambiguity and inconsistency, which have the potential to impede communication, there is mutual understanding.

Cell II represents those role functions, competencies, and personal and theoretical biases that the individual is perceived as having (or expected to have), which he or she may not possess or at least, not be comfortable with acknowledging. Some functions may have "surfaced" during the role negotiation process that the individual had forgotten he or she could perform, or was expected to perform. This cell also includes knowledge, skills, and biases that others assume the individual to have (e.g., because the member is a social worker and the last social worker on the team performed these particular functions) that the individual may not have.

It is not difficult to see the potential problems in Cell II. When someone is unaware of what others think he or she knows and can do, he or she does not understand, and therefore cannot meet their expectations. Why the individual fails to recognize or acknowledge the personal and theoretical biases in Cell II is unimportant. They exist, and others are aware of them. Communication breakdown appears to be a cause *and* an effect of Cell II perceptions.

Cell III is also a potential problem area, because again there are misperceptions. This cell includes biases, knowledge, and skills the individual is *not* willing to share, and functions unique to a discipline which the individual is prohibited from sharing (by professional standards and discipline regulations). Included also are information and skills that are clearly inappropriate or inadvisable for a professional to release to others on the team (e.g., the nurse's responsibility for administering medication). These restrictions limit how much the area of Cell III can be reduced. Identification and release of functions and responsibilities that *can* be shared will contribute to the competencies of other members, and facilitate team effectiveness and efficiency, thereby reducing Cell III. It must be assumed, however, that each member will withhold some portion of his or her personal and theoretical biases. The problem is where to draw the lines. If *germane* information is withheld from other team members (out of fear of exposure, insecurity, defensiveness), communication and interpersonal effectiveness will be negatively affected, and the team's functioning will ultimately suffer.

Cell IV is clearly an area to decrease. As team members acquire new knowledge and skills and learn to communicate more openly, the reduction of this area will be reflected in increased service potential.

The value of the Johari Window is its dynamic character, which is difficult to depict graphically. Enlargement of Cell I requires continuous sharing of relevant knowledge and skills among team members. The role release process is one means of doing this. The effect of enlargement of Cell I will be concurrent reduction of Cell III, as others on the team begin to assume new roles and responsibilities related to the team mission. To enlarge Cell I will require communication, and most importantly, a willingness to negotiate and share.

It is not appropriate here to expand upon Transactional Analysis (TA)

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(Harris, 1969; James & Jorgewood, 1971), but it also provides a framework for analysis of the dynamics of interpersonal communication. TA procedures are effective and simple to learn. Another resource is Gordon (1970), particularly his instructions for "I" messages. If there is team consensus concerning the need for extensive training in communication skills, one or more inservice sessions may be designated for this purpose. The potential these skills offer for improved team collaboration cannot be overemphasized.

Decision-making procedures are closely related to and affected by communication patterns. Parliamentary procedure and vote-taking are the most common procedures for group decision-making. Whatever procedure is selected, the team should decide whether a unanimous vote will be required or whether consensus procedures will be used. The consensus type of decision—where team members who are not in agreement with the decision agree to the action being tested *with the provision* that there will be a subsequent re-evaluation—is most appropriate for working groups such as service delivery teams.

There are various ways to structure the team organization process other than the methods just suggested. Whatever approach is decided upon, the important thing is to establish a foundation for collaboration. The time and energy this requires at the beginning of the school year will ultimately result in savings (to say nothing of more effective interactions) throughout the year. A procedural diagram outlining the steps in team organization is shown in Figure 2. Also outlined on the diagram are the steps in developing a service delivery agreement as described in the next section.

Team Service Delivery Processes. When a group of professionals has reached the point at which they can define themselves as a team, the next order of business is detailed specification of precisely how the team will coordinate to meet student and family needs. Again, there is relatively little assistance in the applied literature. Only a few special education programs, most of which are in the area of the severely/profoundly handicapped, provide detailed descriptions of how teaching staff and related service personnel coordinate assessment, program planning, service delivery, and evaluation efforts. The procedures manual, *Combining a Transdisciplinary Team Approach with an Individualized Curriculum Sequencing Model for Severely/Multiply Handicapped Children*, edited by Guess, Jones, and Lyon (1981), is a notable example. It goes beyond reports of how the transdisciplinary approach *should* facilitate effective collaboration and provides a precise account of team interactions at the various stages of program implementation.

Using this manual as a guide, one school SED service delivery team responsible for young severely and profoundly behavior disordered children formulated the agreement presented in Table 2. This particular team serves eight students with tested intelligence in the retarded range. Behavioral excesses and deficits include extreme social withdrawal, self-

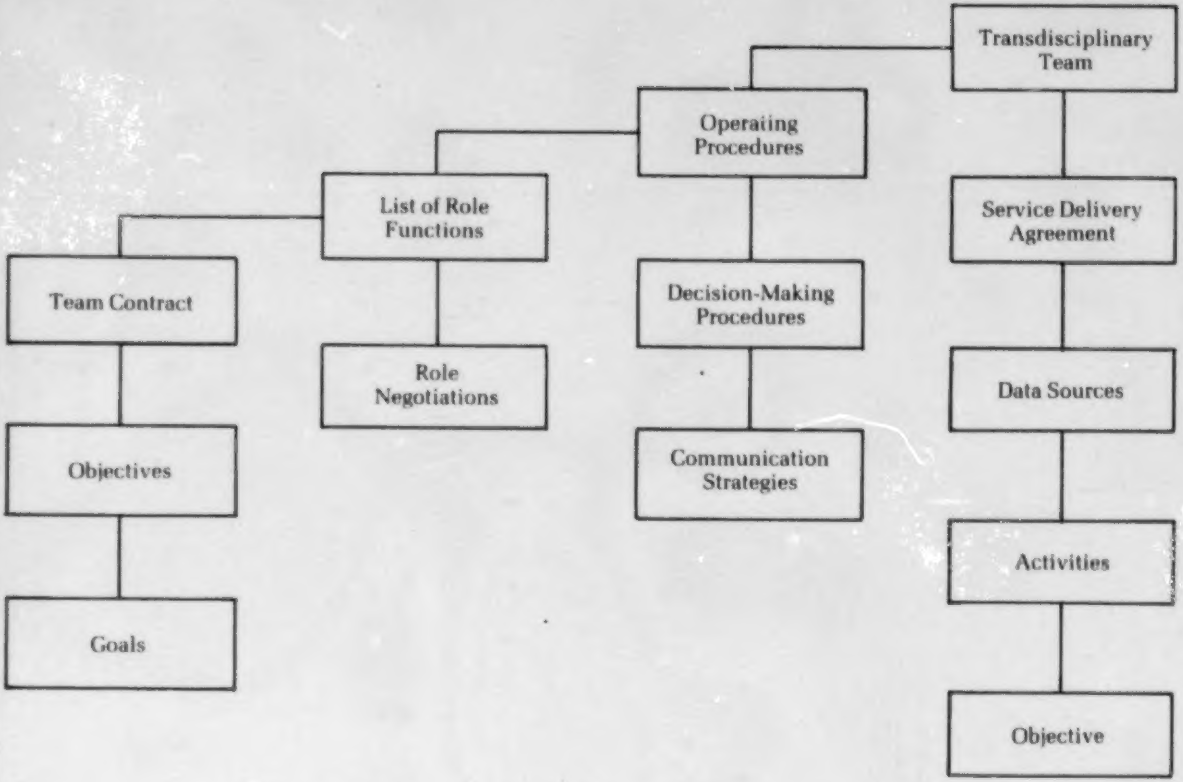
Transdisciplinary Team
Operating Procedures
List of Role Functions
Team Contract
Objectives
Goals
Role Negotiations
Decision-Making Procedures
Communication Strategies
Service Delivery Agreement
Data Sources
Activities
Objective

Figure 2: Procedural Diagram for Service Delivery Team Organization

injurious and stereotypic behaviors, aggression, and severe disorders of speech and language. The team includes a special education teacher and aide, and professionals from occupational therapy, school psychology, speech therapy, and social work. All ancillary personnel are members of *at least* two other teams, so their availability for direct services is limited. Team members were particularly concerned with identifying methods of documenting the implementation of transdisciplinary processes. They began the task of developing their service delivery agreement with three assumptions: 1) transdisciplinary processes have observable products, 2) there are criteria by which to judge these products as appropriate and effective, and 3) there must be individual as well as team accountability. The agreement (Table 2), which specifies coordination of services as well as assignment of individual responsibilities, reflects these assumptions. Once each team member's responsibilities were clarified, delineation of measurable products and specification of data sources for monitoring the processes were relatively straightforward. Thus, the second purpose for this agreement, which was to provide all team members with some degree of accountability for program goals and objectives, was achieved.

At first glance, the documentation requirements appeared to be too demanding, but when the following lists of data were compiled, team members acknowledged that most of these data were already being collected.

1. Teacher records
   a. Assessment schedules
   b. Notebook with dated parent contacts and some indication of the topics discussed
   c. Training schedule for volunteers
   d. Notebook/log with questions/concerns to be discussed with ancillary staff. "Happy faces" and dates after questions/concerns indicate that they were responded to.
   e. Health records for each student

2. Student folders
   a. Assessment protocol
   b. Home skill requirements inventory
   c. Other environments skill inventory
   d. Ancillary staff assessments/reports
   e. Current IEP
   f. IEP development—meeting arrangements checklist
   g. Current programs (with measurement procedures) and activity schedule
   h. Reinforcement survey
   i. Schedules for generalization probes
   j. Current acquisition and generalization data
   k. Changes/adaptations notations on program sheets
   l. Form for noting time spent in mainstream settings

3. Ancillary staff records
   a. Parent and staff needs assessments
   b. Log of contacts with parents and teaching staff for training purposes and indication of training objective
   c. Notebook with date of parent contacts and topic
   d. Evaluations of parent and volunteer training efforts

4. Team records
   a. Team meeting agendas (with dates)
   b. Team meeting minutes with group decisions highlighted

The SED team that developed this document decided to schedule two meetings a year, setting aside at least three hours per meeting for evaluation of team functioning.

Summary

After an overview of team functioning issues, this chapter has attempted to provide some practical directions for development and maintenance of an SED service delivery team. It is directed toward special educators because we are responsible by law for bringing together and coordinating the full array of services for handicapped students. It is also intended for related service representatives, without whom we cannot achieve this goal.

There are always many more answers than there are questions; many more solutions than there are problems. Team functioning issues are no exception. This chapter has borrowed from the practical literature in management and organizational theory to propose what may be termed a "process orientation" to team functioning. In the past, arguments for team organization and effective collaboration have been perceived and presented in the abstract. We no longer have this luxury. Conditions must change if the mandate of PL 94-142 is to be realized. Perhaps the "bottom line" is the need for preservice programs in special education and related disciplines to attend to team functioning issues. Teachers and other professionals concerned with multiproblem children and youth must be provided with training *and experiences* which will prepare them to assume the interpersonal, informational, and decision-making roles that service delivery team organization and management require.

Table 2: Team Service Delivery Agreement

jectives	Activities	Data Sources
Initial and On going Assessment		
1 Teaching Staff	1.1.1 Assemble available student data and conduct additional general assessments/observations to determine child skills relative to the requirements of present and future environments.	Teacher records-assessment schedules Student folders-assessment protocol
	1.1.2 Arrange/schedule specific ancillary staff assessments/observations as determined necessary.	Teacher records-assessment schedules
	1.1.3 Keep parents and team members informed of assessment/observation results and solicit their input in determining skills to maximize each child's independent functioning.	Teacher records-parent contacts Student folders-Home skill requirements form
	1.1.4 Interpret results of general assessments/observations to parents.	Teacher records-parent contacts
	1.1.5 Share results of general assessments/observations with team.	Team records-agenda/minutes of meetings
	1.1.6 Assist ancillary staff in survey of present and future environments to determine skill demands.	Student folders-environmental inventories
2 Ancillary	1.2.1 Conduct specific assessments/observations in their respective disciplines as needed for program planning.	Student folders-Ancillary staff assessment/observation reports
	1.2.2 Assist interpretation of assessment/observation results to parents.	Teacher records-parent contacts
	1.2.3 Share assessment/observation results with team.	Team records-minutes of meetings
	1.2.4 Inventory the skill demands of critical present and future environments (with the aid of teaching staff).	Student folders-environmental inventories
Program Planning		
1 Teaching Staff	2.1.1 Develop tentative IEPs prior to meetings, explain the process to parents and instruct them for involvement, assemble and interpret assessment/observation information schedule/coordinate IEP meetings, and write the final IEP.	Student folders-current IEP and teacher checklist of IEP development/meeting arrangements
	2.1.2 Compare child behaviors with skill demands of present and future environments and develop instructional programs, and schedule activities (with input from ancillary staff).	Student folders-current programs and daily schedule

	2.1.3	Perform reinforcement survey for each child.	Student folders-SR + surveys
	2.1.4	Prioritize skills each child most needs to learn and check to be sure all are age-appropriate and functional.	Student folders-age-appropriate and functional objectives/programs
	2.1.5	Plan generalization probe procedures (with ancillary staff assistance).	Student folders-schedules for generalization probes
	2.1.6	Plan evaluation strategies and specify procedures for collecting probe data (with ancillary staff assistance).	Student folders-measurement procedures on all programs
	2.1.7	Plan for partial integration of students in less restrictive school community, recreational and domestic environments (with assistance of ancillary staff).	Student folders-integration plans
2.2 Ancillary Staff	2.2.1	Contribute to IEP development in areas related to their expertise.	Student folders-evidence of ancillary staff input on IEPs
	2.2.2	Assist teaching staff with reinforcement survey process.	Student folders-SR + Surveys
	2.2.3	Assist teaching staff in prioritizing skill targets.	Team records-minutes of meetings
	2.2.4	Determine parent and staff training needs to implement classroom and home programs.	Ancillary staff records-training needs assessment
	2.2.5	Assist planning for generalization probes	Student records-schedules for routine probes and other evaluation strategies
	2.2.6	Assist planning for program evaluation	Team records-minutes of meetings
	2.2.7	Participate in planning for transition to and maintenance of children in LRE.	
. Program Implementation 3.1 Teaching Staff	3.1.1	Assure that programs and activities are implemented and evaluated as planned.	Student folders-current programs/schedules/probe data
	3.1.2	Maintain communications with and among parents and provide instruction to parents and volunteers (with ancillary staff assistance).	Teacher records-parent contacts, training schedule for volunteers
	3.1.3	Decide when program changes/modifications are indicated (with input from ancillary staff).	Student records-program changes/modifications where indicated
	3.1.4	Collect/record acquisition and generalization data on all ongoing programs.	Student records-current data on all programs
	3.1.5	Negotiate access to, and prepare children for school and nonschool mainstream environments.	Student records-record of time (minutes/hours) in mainstream environments

Table 2: Team Service Delivery Agreement (Continued)

jectives	Activities	Data Sources
2 Ancillary Staff	3.2.1 Train teaching staff and parents as needed to perform specific management functions.	Ancillary staff records-training contacts
	3.2.2 Respond to questions and concerns of teaching staff and parents as these issues relate to specific areas of expertise.	Teacher records-ancillary staff contacts
	3.2.3 Assist parents in accessing community resources.	Ancillary staff records-parent contacts
	3.2.4 Assist teaching staff to keep parents informed of child programs and progress.	Ancillary staff records-parent contacts Ancillary staff records-parent contacts
	3.2.5 Assist preparation of adults for receipt and support of children in mainstream environments.	Ancillary staff records-training contacts
Program Evaluation .1 Teaching Staff	4.1.1 Analyze and feedback program data to the team for decision-making.	Team records-minutes of meetings
	4.1.2 Assure full implementation of evaluation procedures as specified on IEPs.	Student folders-comparison of on going evaluation procedures with IEPs
	4.1.3 Design, construct, and maintain graphs and other monitoring devices.	Student folders-current records/data for all programs
	4.1.4 Interpret achievement and generalization data to the team for program changes if needed.	Team records-minutes of meetings Teacher records-ancillary staff contacts
.2 Ancillary Staff	4.2.1 Provide input and assistance to the teaching staff for decisions related to changing/adapting programs.	Team records-minutes of meetings Teacher records-ancillary staff contacts
	4.2.2 Participate in IEP reviews, updating, and revisions.	Team records-minutes of meetings
	4.2.3 Develop forms for, and assist monitoring of health-related records.	Teacher records-current health-related records
	4.2.4 Evaluate parent and volunteer training efforts.	Ancillary staff records-evaluations of parent and volunteer training

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Delivering Related Services to the Emotionally Disturbed: A Field-Based Perspective

Richard D. Grubb
Murray D. Thompson

Programs for emotionally disturbed children have been intertwined with pupil or related services for many years. The two most common such services provided to emotionally disturbed children are mental health and health services, the latter primarily in the form of psychiatric evaluation. The term "related services" was first defined in PL 94-142 as:

> transportation and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services except such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education and includes early identification and assessment of handicapping conditions in children. (*Congressional Record, 121,* 1975)

The definition is broad and includes any supportive service necessary to assist a handicapped child in benefiting from special education. At the same time, the same services, if they are not considered necessary for a child to benefit from a special education program, are not required to be provided by school districts. In addition, such services usually carry another term, such as pupil services, and are considered separate from the educational program. In contrast, related services are included in the IEP and are to be delivered in conjunction with a special education program. Problems arise when a service such as speech therapy or physical therapy becomes the sole form of special service provided to a child. While revisions to the regulations governing related services are currently being

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proposed, the confusion engendered by previous interpretations is rampant. For example, while PL 94-142 lists speech therapy as a related service, many states classify this service as "special education."

The purpose of this chapter is not to interpret the intent of the related service provision, nor is it within the scope of this paper to address the many issues that impinge on related services. Rather, this chapter will deal with two major related service areas, mental health and health services, from a field-based perspective, and will discuss a model for providing school-based related services.

Mental Health Services

Mental health services for emotionally disturbed children typically include those provided by school psychologists, school social workers, guidance counselors, and psychiatrists. These professionals work from a wide variety of perspectives to provide direct and consultative services to teachers, children, and parents. In many cases, the school psychologist has been seen as a "tester," the school social worker as an "assessor of the home situation," the guidance counselor as a "class scheduler" and "career/vocational counselor," and the psychiatrist as a "rubber stamp, professional labeler." Many of these professionals, however, have developed their roles well beyond these stereotypes, and currently mental health services are being viewed more comprehensively. A review of formal and functional job descriptions in most educational agencies would reveal great overlap in these four professional areas. As a result, there is now a need for functional role descriptions of mental health services rather than definitions based on professional certifications. Development of these descriptions requires first a task analysis of the responsibilities, followed by an assignment of these responsibilities and a plan for coordination and integration of efforts. Role definitions based on individual areas of "paper certifications" cannot be expected to result in the provision of comprehensive, nonredundant services.

Health Services

Health services typically include those services provided by a school nurse, physical therapist, occupational therapist, physician, dentist, dental hygienist, or other medical persons. Because medical services under PL 94-142 are allowed only for the purpose of diagnosis and evaluation, a dilemma exists. On the one hand, it seems appropriate to restrict medical services to diagnosis and evaluation, or related services could become the "national health insurance for exceptional children." On the other hand, with any kind of assessment, one must always ask, "Assessment for what?" Assessment is pointless if it does not lead to intervention and treatment, which may not be available through other agencies. For example, psychiatrists may intervene with the family or provide therapy in addition to prescribing and monitoring medication. Both of these types of services go beyond diagnosis and evaluation, and from a functional perspective, are allowable under related services. However, in the case of psychotherapy, for example, if this service is provided by a psychologist, social worker, or guidance counselor, it appears to be allowable. This same service, however, could not be provided by a psychiatrist, because the psychiatrist is limited to providing medical services for diagnosis and evaluation only. As this seems to be professionally discriminatory, it has raised issues of "restriction of trade" by the medical community.

A broader definition of medical services, which includes treatment, places education in a position whereby it could become that "national health insurance." On the other hand, to restrict all medical services to diagnosis and evaluation seems to limit the value of the services.

Even the courts seem to be confused about the issue of "medical services for diagnosis and evaluation only," and court rulings have been inconsistent. A prominent example is the issue of catheterization, which has been ruled upon in different ways by the courts. These cases have far-reaching implications not only for special education, but perhaps for public education as well. After much debate, catheterization was defined as a related service by the U.S. Department of Education on January 19, 1981. However, school districts resisted providing this service until September 8, 1981, when the Third Court of Appeals in *Tokorak* vs. *Forest Hills School District* ruled that school districts must provide catheterization to all children requiring it. The importance of this decision is clear. Catheterization is a medical service; furthermore, it is needed by children who do not necessarily require special education. It is also not diagnostic or evaluative in nature. If court decisions such as this hold up under appeal, a situation exists in which special education may have responsibility for providing essentially all needed medical services to exceptional children. In fact, taken to the extreme, related service could be interpreted under the clause " . . . and whatever other services may be necessary for children to benefit from special education" to include such things as school lunches.

While these issues are indeed far-reaching, they have been mentioned here only to provide a brief introduction to the complexity of the related services issue. A delineation of some practical issues that accompany the provision of related services to special education students within public schools follows.

Issues in Related Services

Home/School Communication

Comprehensive family support systems are exceedingly useful in providing related services to exceptional children. Obviously, the influence of the family on the child in such things as attitudes, motivation to learn, behavioral tendencies, and achievement is significant, and the professional person who ignores this resource may spend large amounts of time rediscovering what is already known. Family resources that are available to a team of related services professionals are too frequently ignored or minimized—parents can provide large amounts of useful information to school personnel. In addition, they can be trained as observers, materials developers, planners, tutors, and evaluators of their child. In some cases, parents can be directly involved with educational program planning and decision making, and function as full members of a multidisciplinary team. On the other side of the coin, more can be done to enhance parenting skills, provide useful information to parents, and assist them in developing both realistic and yet optimal expectations for their children. Few professionals and perhaps fewer educational systems have successfully accomplished this reciprocity with parents. Parents of exceptional children and schools are too frequently in adversary positions. A more cooperative approach that will ultimately assist children includes home visits, parent-professional conferences, inservice sessions on effective parenting, parent-school visitations, parent advisory groups, parent lending libraries, and small issue-oriented parent discussion sessions.

The trend whereby the schools have assumed more and more responsibilities that have traditionally been with the family can be reversed by working intensively with families, thereby "giving away" the skills and knowledge of the professional. This "giving" involves such things as increasing parental expectations and knowledge and awareness of the educational needs of their handicapped child.

Coordination of Services

The coordination of agency services is a critical factor in developing a related services system. A number of models for developing interagency cooperation exist. All involve the assignment of responsibility for the coordination of school and agency services provided to children within that system. To accomplish this, some school districts use the case manager concept, whereby an individual is assigned as the manager for an individual case and is required to coordinate the case from beginning to end to ensure that comprehensive, nonredundant services are provided.

Interagency agreements exist at the federal level, and many states have one or more interagency agreements in place. A variety of interagency agreements exist at the local level, and obviously there is much to gain by negotiating such agreements wherever they are feasible. Even without these formalized administrative agreements, related services providers can do a great deal to coordinate school and agency services by making a concentrated effort to share information, develop positive communication, and develop positive interpersonal relationships with their counterparts within the various agencies that jointly serve their children. These agreements have been slow in coming and were virtually unheard of until recent years. Perhaps this situation will change as the "team concept" is utilized to a greater extent.

Accountability

It appears that accountability issues will be primary concerns for related services providers for some time to come. Compliance monitoring, an extreme example of accountability documentation, involves the risk of putting an overemphasis or an inappropriate emphasis on accountability. As such, an overemphasis on documenting accountability may result in a condition in which professional persons spend increasing amounts of time documenting actions and less time documenting effects on children. The need to assess and document accountability is extremely important, but it should be done without significantly reducing the amount of time that can be spent providing services. Accountability may be documented quantitatively and/or qualitatively in a highly sophisticated sense, or it may be as simple as anecdotal information provided in response to an open-ended question, such as: How do you know that what you did last year made a difference?

Staff "Burn Out"

Related services providers, by the very nature of their jobs, are in a position in which they can be overwhelmed and can "burn out." Moreover, the current political and economic climate in this country is such that related services professionals are being asked to do more with less. Particularly disturbing is the amount of paperwork, meetings, and similar "bureaucratic" work being required by districts. In addition, many professionals are finding that political sophistication is becoming more and more important, and the individual who used to think that he or she would be in the full-time business of providing direct services to children, teachers, and parents is now mired in sensitive negotiations and public relations efforts. No one can intelligently dispute the importance of these efforts, for the best services in the world will not be supported by taxpayers unless taxpayers are aware such services are being provided and are aware of their effectiveness. However, professional organizations must become more protective of their members and must first seek to relieve members of the public relations demands of their job and then, as a group, must seek more efficient and effective ways of dealing with the paper flow, preferably through eliminating it. In any case, professional organizations should take the lead in finding ways to deal with professional burn out.

The Need for Action-Oriented Persons

In order to have an effective system of related services for teachers, parents, and children, it is necessary to have individuals who have the courage of their own convictions. If ambiguities exist, someone must be willing to take a stand. For example, if a working definition of psychotherapy is deemed necessary, and individuals at the state and federal levels are unable or unwilling to define the term, then it falls to someone at the local level to operationalize that particular term.

Sometimes the related services provider finds him- or herself in a situation in which the only choices are "wrong" or "wrong." For instance, when an exceptional child moves into a school district without his or her educational records, a dilemma exists because this child is legally entitled to a free and appropriate education on his or her first day within the new school district, but at the same time, the decision regarding this legal right cannot be made without adequate information. When the choice is between "wrong" and "wrong," it is a given that a wrong decision will be made. The only resolution is to make the less wrong decision and make the best of it. In this particular case, this can be done by involving related and instructional services persons immediately in data collection and assessment procedures.

It is always important to realize that the best decision making in the world is appropriate only momentarily, unless that good decision is also accompanied with good documentation. Decisions based on good documentation are usually the ones that carry the greatest weight over long periods of time, even if the decisions per se are not that great.

While these issues are both genuine and generic, they do not address the more basic issue of how to provide related services to children. Following is a description of an organizational concept that has ramifications for assisting individual professionals in addressing the issues discussed previously.

The Multidisciplinary Team

The use of a team concept to provide support services to the exceptional child builds upon the technology, professional expertise, systems, facilities, and staff already inherent in an educational system designed to make it a more unified, goal-oriented organization. As a result, the provision of support services achieves a greater level of efficiency, operational effectiveness, and direct relevance to the student's needs. In addition, use of a multidisciplinary team (MDT) can address the issues of territoriality and overlapping functions.

One concept basic to this team orientation is that all support services are specifically focused on the child, regardless of professional orientations. Among the team members, child-focused issues are documented, such as identification of learning needs, appropriate related services, appropriate placement, appropriate curriculum materials, learning styles, and home/school communication. Problems are defined, discussed, and resolved.

and provisions are made across disciplines for capitalizing on a child's strengths. Because of the variety of decisions, the structure of the team is important. Ideally, the team should cut across levels within the organizational structure as well as across departmental and expertise boundaries.

The teacher and administrator in a building in which a team of related services professionals is already functioning is in an enviable position. However, a MDT can become a "monster" if inappropriate techniques are used. The leadership must ensure that the team is more than a group of individuals each "doing his or her own thing," and that counterproductive and/or extraneous efforts are kept to a minimum. Leadership must ensure that the efforts of each individual contribute to the "whole" of the process. Data collection must be seen as a systematic team effort that is planned before the fact, instead of the situation in which individuals collect independent data and then the team attempts to coordinate efforts. The team must plan carefully for intervention, evaluation, and follow-up if the pieces are ever to fit neatly when the team attempts to put the puzzle together. Strong leadership is necessary to deal with communication, territoriality, and similar issues. Ownership for team processes and products should be shared by each member.

An Integrated Model for Providing Related Services

The use of a team approach to educational decision making is a well-accepted and established practice. Maximum productivity of the team requires an intergrated effort such that synergy will result in a "whole" greater than the sum of the parts. However, the use of a team in this integrated, systematic, productive manner is not well established. An example of a model that addresses this team approach is presented in Figure 1.

This model depicts a situation in which persons at the first administrative level, such as a building principal, are in direct contact with and provide administrative leadership to teachers, related services providers, and supervisors. This is in contrast to the organizational model in many educational systems in which the distance between persons on traditional organizational charts is also reflected in daily, routine interactions. Also in contrast to a traditional model in which administrators are almost solely concerned with administrative duties as mandated by state statutes and local rules and customs, this model places administration directly on the borders of other areas, reflecting the expected day-to-day interaction with these groups.

The primary role of administration in this model is conceptualized as leadership for the educational team. All primary actions are ultimately aimed towards the child, who is considered central in this model. With such a model there would be no need to coordinate a number of systems,

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because administration would provide the central leadership for the entire system. Even the participation of central office supervisors would be under this administrative leadership, a situation which is in marked contrast to more typical models in which administrators and supervisors exist at similar organizational levels.

The primary emphasis in this model is on support to the child, with most of the direct services coming from related and instructional services providers. Supervisors of instruction provide teachers with general support, whereas related services providers and their supervisors provide teachers and children with a variety of specialized supports.

Related and instructional services providers in this model have a direct link with each other and have access to a core of supervision within their areas of expertise. Because they each have direct links with family and community agencies, good communication between related and instructional services groups is absolutely necessary.

The role of administration is to establish and maintain an organizational framework that will function efficiently and effectively, including coordination of activities and the development of positive communication within the entire system. Administration typically would deal with the supervisors of related and instructional services on some issues, and with related services providers and teachers of regular education, special education, and special areas on other issues. Administration rarely would have direct interaction with family and community agencies. Exceptions to this would be administrative involvement with parents on IEP development and similar procedural matters.

The direct link between related services and instructional services is important. Input to teachers from a group of specialists is at a level of peer interaction which allows for dialogue, discussion, and debate. Professional growth of the related and instructional services providers comes as a result of peer interaction around specific issues and the generalization from these specific issues to other issues. Interaction among related and instructional services groups and their supervisors is designed to increase skills and competence within their own areas of responsibility as well as other disciplines. Interaction among related and instructional services professionals in providing services to the family should be direct and continuous. Ideally, the primary link between home and school is through instructional and related services staff who interact with the family on an as-needed basis. Supervisory staff usually interact with family only on a referral basis from related and instructional personnel.

This model depicts a number of areas in direct contact, and it is expected that action links exist along each of these borders. The action may be in the form of shared information, discussion, debate, problem solving, or other activities. Where direct links do not exist, awareness or information links are still important. One common way of maintaining awareness links is by sending carbon copies of individual and team reports and memos to all persons in the system, in addition to those involved in direct interaction. As an example, supervisors need to be aware of what other supervisors are doing. Additionally, supervisors of instruction need to be aware of the related services provided by the teachers they supervise, the students in those classes, and the parents of those students. Also, in order to be effective in their roles, supervisors of related services providers need to be aware of what is going on within classrooms, and with family and agency contacts.

The MDT Process

To achieve maximum success and continuing value, MDTs must become a way of life for educational organizations. The approach taken to implement MDTs in an educational system consists of a number of parts.

Develop Goals. Formal and informal needs assessments should be conducted with the consumers of the related services. An on-going needs assessment via dialogue, discussion, and debate with groups of these consumers is more desirable than a one-time "paper and pencil" device, although this may be a good starting place.

Specify Roles. The roles of related services providers must be tailored to the identified educational, health, and mental health needs of children. Roles and tasks should be delineated and assigned early in the process to 1) ensure comprehensive services with minimal service gaps, 2) provide complementary services, and 3) prevent service redundancies.

Develop Communications Lines. The goals, objectives, and fundamental structure of the program should be communicated and reinforced by all levels of the educational organization. It is critical that the MDT be initiated with a clear understanding of its purpose and with a commitment to its desired outcomes. Effective functioning of the MDT requires that this communication take place. This step will facilitate knowledgeable participation of all professionals as well as group commitment.

Formal and informal communication networks among related and instructional services providers and supervisory and administrative supports are very useful to the individual development of professional staff. Periodic meetings among and within these groups (in addition to the regularly scheduled MDT meetings) are desirable. Reciprocal technical assistance and inservice can be effectively utilized among team members.

Develop a Plan to Achieve Goals. This plan should include assessment, intervention, refinement, and evaluation.

Refine System. Irrelevant, non-productive tasks must be sought out and eliminated. A formative, on-going process evaluation is needed in which strengths and weaknesses are considered relative to cost-effective and cost-efficient aspects and are continuously monitored relative to desired goals and outcome behaviors.

Provide Training. The members of the MDT have a variety of roles and responsibilities within the team for which they must be trained. These roles are over and above their specific areas of professional expertise and must be geared specifically to the successful functioning of the team. The major contributions include resource provision, decision making, and process facilitating. When each team member is trained in interactive skills and understands the group process, the result is active participation and an open, student-centered, action-oriented environment.

Specific skill training and information dissemination can be planned by using individual team members in a sharing process with colleagues by providing good administration and supervision, and by utilizing outside resources and resource persons appropriately.

Schedule Regular Meetings. MDTs should meet on a regular, perhaps weekly, basis and should include all members. Meetings should have a clear agenda; the sessions should be task-oriented and should seek specific problem solutions with clearly identified next steps and a clear definition of roles and responsibilities of team members.

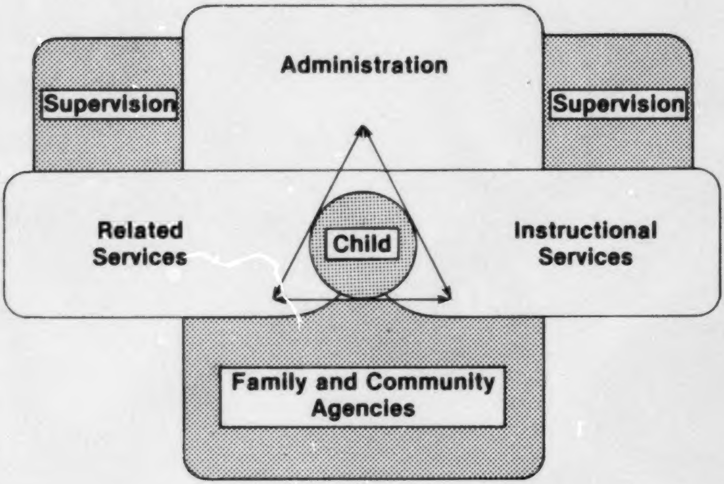
Follow Up. To assure that the good ideas and next steps that were generated during team meetings are acted upon and achieved, it is essential that follow-up occur. There is a need for each team member, especially those designated in leadership roles, to meet his or her activity commitments (next steps) for the team effort to be effective. Procedures (feedback loops) must be implemented to track the program and to provide opportunities for the teams to evaluate programs developed and to refine and improve programs on a longitudinal basis. The major focus is the "fit" of the support service program to meet the needs of the students for whom it is intended. This total organizational involvement will have a significant, positive impact on the continuing value of the MDT.

Conclusion

The MDT as described is only an outline of a model. It represents one approach to dealing with the fragmentation of services and the overlapping of resources so often seen in related services areas. The area is neither without controversy, nor at this time is it known what may in fact happen with respect to related services in special education. However, even given more latitude in interpreting the regulations, school districts will likely continue to provide supportive services to emotionally disturbed and other handicapped students. Furthermore, they will continue to struggle with how to provide the most effective service in the most cost-effective manner.

Certainly one answer to the dilemma is to organize services in a manner that expedites their delivery, allows for a sharing of the general burdens of paperwork, and provides for open and quick communication. The building-based MDT appears to have much to recommend it as such a system.

Figure 1: Integrative Organizational Model


Administration
Supervision
Supervision
Related Services
Child
Instructional Services
Family and Community Agencies

Related Services are defined in H.B. 94-142.

Note: Instructional services include regular education, special education, and special area teachers. Community agencies are seen as an extension of family and not as an entity in the system in and of themselves. Additionally, an agency may stand in the legal role of parents.

Inservice Training for Teachers of the Emotionally Disturbed

Richard S. Neel

For teachers of the emotionally disturbed, an emphasis on inservice training has become a major focus over the past several years. This emphasis on the additional or continued training of already employed personnel, as opposed to preservice training prior to employment, has occurred for several reasons: the reported current shortages in the availability of qualified full-time teachers; high attrition rates among staff and the use of a large number of temporarily certified personnel (Grosenick & Huntze, 1980); and the passage of PL 94-142. Both regular and special teachers must not only understand the intent and requirements of PL 94-142, but must update their knowledge and learn the skills necessary for its proper implementation (Skrtic, Knowlton, & Frances, 1979); a tremendous gap exists between the expectations outlined in the law and the current knowledge level of these teachers. Most regular education teachers feel that they lack the skills needed to integrate handicapped children into their classes successfully (McGinty & Keogh, Note 1). It has been estimated that over two million regular educators and 250,000 special educators will require inservice training to do their jobs adequately (Gall, 1977; Skrtic et al., 1979).

Involvement of teachers in the planning and implementing of inservice activities has become one of several issues to be considered in the development of comprehensive inservice programs. Appropriate funding is another element of successful implementation. Superseding these issues, however, is that of delineating the specific role of inservice training.

Inservice Issues

The Role of Inservice Training

The role of inservice training is the transmission of new skills and knowledge to career teachers. Too many inservice programs, however, are designed without regard to research findings; without long-range goals; without coordination with other resources, programs, and community needs; and sometimes without the input of the teachers themselves (Berman & McLaughlin, 1978; McLaughlin & Marsh, 1978; Houston & Freiberg, 1979). There are various philosophical views on the role of inservice training—the remedial view, the developmental or growth view, and the problem-solving view—each of which differently influences the design and goals of inservice programs.

The remedial view (Jackson, 1971; Skrtic et al., 1979; Tyler, 1971) holds that inservice training should correct deficiencies. This point of view assumes that something is wrong with the way teachers operate and inservice training is needed to fix it. And, as teachers are unaware of their deficiencies, someone else must diagnose their condition and prescribe a remedy (Jackson, 1971). As Shanker puts it, proponents of the remedial view maintain that inservice is to be used to "crack incompetents in line . . . ." (Ryor, Shanker, & Sandefur, 1979, p. 16). The remedial view requires focus upon specific content areas in which an expert trains educators in a specific subject, such as reading, mathematics, or social studies. Other examples include the psychologist who teaches educators about child development, the mental health consultant who helps teachers cope with students with problems, and specialists in classroom management who help teachers use various programmatic and reinforcement strategies (Schmuck, 1979). More and more school districts are hiring full-time content specialists to maintain contacts with outside experts, to design and arrange inservice workshops for teachers, to select instructional materials, and to train individual teachers in new concepts and skills.

In contrast to the remedial view, the developmental, or growth, view of inservice training holds that each professional should develop skills according to individual interests and capabilities, rather than learn specific skills mandated by administrators. The developmental perspective assumes that teaching is a complex activity about which there is always more to learn. According to Nemser (1980), the motive behind inservice involvement is "not to repair a personal defect, but to seek greater fulfillment in teaching" (p. 4). This perspective accepts the importance of the experience of teaching, and the goal of inservice training is "to increase teachers' awareness of what they do and to support their efforts to improve" (Nemser, 1980, p. 5). The teacher is encouraged to seek teaching activities that will foster his or her growth rather than grow to fit the job, as in the remedial approach. The developmental perspective is favored by many inservice specialists and there is an increased amount of attention given to supporting professional development (Feiman & Floden, 1980; Field, 1979; Hall & Loucks, 1979).

A third approach to inservice education is focused on problem solving. Drummond (1979) has recently proposed this problem-solving view, which consists of three complementary components: outside linkage, situational learning, and problem management. Outside linkage is a technical assistance model in which a specific solution comes from an outside source. In the situational learning component, the teacher learns the skill of problem solving, rather than a specific solution. The problem management component involves changing the existing system and the behavioral norms of people within the system. This problem-solving approach focuses upon the ongoing process of problem solving and change, rather than the specific final products or outcomes of a program.

This approach is advocated by The Quality Practices Task Force of the National Inservice Network (1980). The Task Force describes such an approach as beginning

> with the identification of needs—organizational, programmatic and individual needs—which moves through planning and management to program evaluation, which then loops back into ongoing needs identification. Threaded throughout the process, . . . is a focus on students. This focus recognizes student needs, student involvement, and attention to the impact upon students of inservice activities. (p. 3)

Teachers begin with a problem and collaboratively seek solutions. Staff developers with this perspective concentrate on understanding teachers, perceiving the challenges they face, and providing the kind of support they need to understand and tackle the complex problems of public education.

No consensus has been reached as to which approach to the design of inservice programs is best. The remedial approach is often favored for short-term training objectives. When long-term programming is the focus, developmental approaches are preferred (Edelfelt & Lawrence, 1975; Gallegos, 1979; Rubin, 1971; Skrtic et al., 1979). The problem-solving approach, however, combines the specific skill acquisition aspects of the remedial approach with the productive aspects of the developmental view. The administrative focus is on the process of problem management and on how the organization is maturing in its ability to identify and solve the problems occasioned by the requirements of the job and by the personal growth needs of staff members. Such an eclectic approach holds the most promise for effectively meeting the wide variety of inservice needs of teachers.

A first step, then, toward developing a comprehensive inservice program is to determine the role inservice training will assume in the particular situation. Is it to remediate inadequate teaching skills, encourage professional development and growth, solve individual, school and community problems, or a combination of all of these? Until the specific purpose of a particular inservice training situation is clearly delineated, implementing effective programs is impossible.

The Funding of Inservice Training Programs

The funding of inservice programs is another obstacle to effective implementation. Inservice training has always been the stepchild of preservice training. When budgets are planned, inservice programs are usually added last and are the first to be cut. Most programs are squeezed in here or there. Financial incentives are given for classes which are taken anywhere, on any topic, with no requirement that they be part of an integrated, goal-directed program. Most inservice efforts are singular and isolated. They either are directed toward personnel at a single institution, or else they rely upon only one source of expertise. Institutions of higher education frequently plan and conduct inservice programs without involving the people who are to receive the services. Such unilateral efforts are no longer appropriate (if they ever were!) (Houston, 1979). Collaborative efforts, using the strengths of local and state education agencies, as well as those of institutions of higher education and professional organizations, need to be developed (Skrtic et al., 1979). There is no shortage of need for inservice programs. As Ryor et al. (1979) point out, if adequate comprehensive inservice programs were planned and implemented, they would exhaust all available training personnel.

The low priority of inservice programs is reflected in their funding level. Until recently, a majority of inservice training programs were funded exclusively by the recipients. Education inservice is different from other professions because the cost cannot be passed on to clients through fee structures (Ryor et al., 1979). At the same time, employers traditionally have not financed developmental or growth programs. The cost of inservice training, then, falls squarely on the shoulders of the teachers. The motivation is either pride or, far too often, the removal of job stress (i.e., negative reinforcement); handicapped children produce a lot of stress in the educational system. This stress is strong enough to motivate the teachers to seek inservice training on their own. This individual effort relieves school districts of the need to provide a comprehensive developmental inservice program; however, school districts must pay part, if not all, of the expense to provide remedial inservice training to all personnel. Many believe that districts should pay for job-related remedial inservice training and then leave the cost of developmental inservice training to the individual. Such a separation may be necessary if the goal of a district-sponsored comprehensive inservice plan is to be realized. Even with increased federal support for state and local inservice, available resources for a remedial and a developmental inservice plan would fall short. It is feasible, however, to combine local and federal support with incentives such as release time or academic and salary credits to provide a continual job-related inservice program (Skrtic et al., 1979).

The combination of the commitment of sufficient resources to fund a job-related inservice program and the encouragement through incentives for personal growth is a necessary second step in developing a comprehensive inservice program. The challenge of PL 94-142 can only be met if well-trained regular and special educators are available (Brown & Palmer, 1977). Inservice training must become the major emphasis in the preparation of personnel to meet this challenge.

The Roles of Teachers and Teacher Trainers in Inservice Programs

Who should *provide* inservice training has occupied more space in print than who or what *should be trained*. In education, institutions of higher education have dominated both preservice and inservice training programs, differing from other professions, such as medicine or social work, in which professional organizations provide the bulk of inservice training (Houston & Freiberg, 1979; Ryor et al., 1979). This domination is changing; more and more state and local agencies are designing and implementing their own inservice programs.

The collaborative efforts in inservice mentioned previously (Skrtic et al., 1979) certainly are the preferred method of inservice design and implementation (Bensky, Shaw, Gouse, Bates, Dixon, & Beane, 1980; Meyer, 1969; Ryor et al., 1979; Shaw & Bensky, 1979; Skrtic et al., 1979). As Shaw and Bensky point out, however, the collaborative effort must focus on increasing the investment of the teachers in process. They suggest designing inservice programs that are based on staff needs. The Rand Study on School Change (Berman & McLaughlin, 1977) found that teacher efficacy and involvement are the keys to change in schools, yet teachers have had the least input with regard to inservice training (Orrange & Van Ryn, 1975). Shaw and Bensky also encourage the use of local teachers in the design and implementation of programs. They are not merely suggesting that institutions of higher education include local school personnel in a support capacity as part of a university controlled inservice; rather, they propose that local regular and special educators should assume the roles of planners and teachers, utilizing assistance from other sources, such as institutions of higher education, as needed.

Guidelines for Effective Inservice Programs

Shifting the focus of control of inservice program design to classroom teachers will obviously create problems. Of major concern is the determination of who is best able to decide what is the best training. Program personnel should be selected according to their knowledge, skills, and credibility among peers (Meyer, 1969). To date, inservice decisions have been based on tradition or the bias of individual administrators. Very little empirical data exists on how to provide inservice, or even what inservice to provide (Cruickshank, Lorish, & Thompson, 1979), and clearly, more work needs to be done in this area. In a recent review of empirical studies of inservice programs, Cruickshank et al. (1979) identified four major trends with regard to both approach and implementation, based upon their review of the 1974 Florida Department of Education study of teacher change (Lawrence, Baker, Elizie, & Hansen, Note 2). They caution, however, that the reporting methods chosen by the Florida group may be misleading, because cases with different numbers of subjects were weighted equally. The four trends reported are:

1. Movement from compensatory to complementary view of inservice (cf. Skrtic et al., 1979).
2. Trend toward continuous rather than discrete inservice (cf. Skrtic et al., 1979).
3. Change from addressing relatively simple problems to dealing with the more complex ones (cf. Drummond, 1979).
4. Movement from narrow control by school administrators and/or universities to more collaborative efforts that include classroom teachers (Rand, 1978).

In general, it appears that inservice training is becoming more broadly conceptualized and recognized as a major variable in implementing comprehensive educational programs for all students—handicapped and nonhandicapped. Regardless of emphasis, any inservice program should be developed with specific objectives and along defined guidelines, and not in the ad hoc fashion which is so often seen.

The extensive literature in this area would seem to suggest some general guidelines for any inservice program. First, the content of inservice programs should be based upon an asssessment of the specific strengths and weaknesses of the teachers. Self-evaluation is an essential element of this assessment (Bensky et al., 1980; Berman & McLaughlin, 1978; Ryor et al., 1979; Skrtic et al., 1979). Second, inservice programs should provide a variety of ways to learn each skill (Lawrence, 1974). Truly individualized programs must be available for each teacher in order to ensure the acquisition and maintenance of desired skills. Third, the evaluation of inservice programs should include multiple measures. Houston and Freiberg (1979) suggest measuring both child and teacher behavior change, teacher knowledge, consumer satisfaction, and attendance; Skrtic et al. (1979) also recommend evaluation of behavior change in both the teachers and children. For additional, more specific guidelines, the reader is referred to Edelfelt, 1977; Siantz and Moore, 1978, and Lawrence, Baker, Elizie, & Hansen, Note 2. It should be iterated, however, that although these guidelines are reasonable and certainly appear to be valid, the empirical bases for these recommendations are tentative at best. More research is needed in this area before more comprehensive guidelines can be suggested.

Inservice Training for Teachers of the Emotionally Disturbed

Much of what has been discussed thus far can be applied to inservice programs for teachers of both handicapped and nonhandicapped students. Inservice programs that focus upon emotionally disturbed children, however, must be concerned with the unique difficulties these children present both for special educators and for the increasing numbers of regular educators who encounter these children in their classrooms. Emotionally disturbed children affect all aspects of the teaching environment. The inservice training needs created by the presence of these children within the public school environment are perhaps, in general, no different from those related to other handicapping conditions. There are, however, certain considerations which should underscore the need for intensive inservice with teachers who are involved with this population.

Ecological theorists point out that children who are identified as emotionally disturbed are producing the most disturbance in the system. One common technique for lessening that disturbance is to isolate the child and then change his or her behaviors. The result is often a reduction in disturbance of the system as a whole and the teaching of academic and social behaviors in an isolated, controlled setting. The system is quieter, the student is making gains, and everyone is relatively happy—until the child is returned to the system. Far too often, the old disturbances reappear and apparent success is now dismal failure.

The solution is relatively simple. First, do not isolate the child. The content of his or her learning is the social milieu of the entire school. Cues and discriminations, if learned in that setting, will more readily apply to other natural settings. Unfortunately, to maintain the behavior disordered student in the school milieu requires a trained staff. Thus, the entire staff of a school must become involved in specialized inservice programs.

Teacher Competencies

Certainly all teachers who work with the handicapped have need for specific content expertise in functional assessment of child behaviors, identification of individual programming needs, and specific instructional strategies. In addition, teachers need to know how to engineer environments to accommodate both the instructional and behavioral needs of emotionally disturbed students. Stainback and Stainback (1980) have suggested that this may be a most critical factor in programming for emotionally disturbed students. They suggest that educational practices for emotionally disturbed students do not differ qualitatively from good teaching practices; rather, changes should be made in terms of individualizing objectives for instruction and behavior management. Thus, while the content of inservice programs should give consideration to the basic

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principles of good instruction, attention should also be paid to the management of the emotionally disturbed student within the entire school environment. This movement away from isolated behavior change to consideration of student behavior in the total environment marks one of the major trends in educational intervention for the emotionally disturbed. It also poses one of the major challenges for inservice training programs.

Teacher Stress

The adaptability and resiliency of staff often wilts or disappears in stressful situations (Selye, 1956; Styles & Cavanaugh, 1977), such as educating emotionally disturbed children in the natural school setting. Bensky and his colleagues (1980) found that teachers experienced the most stress when they perceived a discrepancy between what they could do and what others expected them to do. Certainly, PL 94-142 has altered the expectations of all educators. In addition to the expectation that teachers will be able to implement IEPs, there is also the expectation for the emotionally disturbed student that he or she be "controlled"—that the student neither disrupt nor interfere with others in the school. This expectation that teachers maintain order is certainly a major stress inducer for those teachers responsible for emotionally disturbed students. All staff members in the school require a variety of skills for working with these children, especially in regard to the planning of learning activities, the selection and adaptation of materials, appropriate programming and scheduling of work tasks, behavior modification, maintenance and phasing-out of program activities, as well as good teaching practices in general (Gallaher, 1979). Yet one training package which can meet all of these demands is not available (Nelson, 1978).

Comprehensive Inservice

Because of the degree of impact emotionally disturbed students have within the school environment, public schools have tended to isolate them in special facilities or classes (Grosenick and Huntze, 1980). The mandate for integrated services or education in the least restrictive environment created by PL 94-142 becomes particularly critical for the more mildly or moderately emotionally disturbed student—that is, the student whose behavior is serious enough to interrupt learning in the regular classroom, but who also needs to remain within the public school program.

These children do not need to be placed where they can receive special services and be managed; rather, the services and the management of their behaviors needs to occur within the regular classroom to the greatest extent possible (Deno, 1970; Birch & Reynolds, 1977). Certainly, this perspective places a great demand on regular as well as special educators. All emotionally disturbed children require a full continuum of community-based services that involve not only school teachers, but also ancillary personnel, such as physicians, nurses, psychologists, psychiatrists, social workers, juvenile officers, counselors, and consultants. Thus, the traditional separation of school and community can no longer exist. This change in scope will require a new type of educator, one who can manage all segments of the community. In addition, the teaching tasks of everyone concerned will have to be redefined. Until these requirements are met, presumably through inservice programs of some kind, the education of all emotionally disturbed children will be hampered.

Obviously, discrete, university-based, categorical inservice programs will not suffice. On the other hand, the school-based programs which have been successful have focused upon the situational requirements of a specific institution and have incorporated the efforts of all of its staff members (Knight, Meyers, Paulucci-Whitcomb, Hasazi, & Nevin, 1981; Nelson & Stevens, 1981). Most school-based programs are competency based and provide an ongoing relationship between the teacher and the trainer. With an increased reliance on the teachers as trainers, such a model becomes cost effective. Within each program, a wide variety of options must be developed to meet the needs of the various staff members. Even the other children in the school can become recipients of inservice training, especially since they are important actors in the school's social environment (Sullivan, Note 3).

A Model for Inservice Training

A promising approach which may address the need for comprehensive inservice is to provide training within the context of direct service delivery to the emotionally disturbed students (Nelson, 1978). This notion requires a reconceptualization of the special educator's role as well as a rearrangement of the context in which services are provided. The teacher consultation models are examples of this approach. There are several permutations of these models (cf. Deno & Mirkin, 1977; Lilly, 1971; McKenzie, Egner, Knight, Perelman, Schneider, & Garvin, 1970). The basic premise of these models is that the special education teacher provides service to the student through the regular classroom teacher. That is, the special educator serves as a consultant and resource to the classroom teacher, assisting in developing instructional plans, implementing teaching programs, and managing student behaviors. The value of such a model is that the student remains in the mainstream and learns within the natural social environment, and the classroom teacher, as well as other professionals, receives inservice that is continuous and based on his or her individual needs for skills and support. The training is not only individualized, but occurs informally, is not episodic, and takes place within the context of the classroom. This model, however, which has been demonstrated to be effective with students, has not been widely adopted by schools, according to Nelson and Stevens (1981). They cite several reasons for this lack of implementation, including the policy of restricting special educational services to those students who meet the criteria for being "seriously" emotionally disturbed, a factor which they assert is not conducive to mainstreaming. Additional resistance has come from administrators and teachers who do not support the concept or lack the motivation to improve their teaching skills.

Conclusion

The foregoing discussion has considered various aspects of inservice planning and implementation for the purpose of stressing a particular point—that each inservice program for teachers of the emotionally disturbed must be unique, and developed in each setting by the personnel in that setting (Neel, 1981). There will, of course, be commonalities in content, instructional technology, and delivery methods to ensure conformity with the guidelines established in PL 94-142, and the basic principles discussed previously, but the final plan must reflect the individual needs, philosophy, and ecology of each school, and the specific children they serve. The thrust of the inservice program should be to train the staff to identify and classify its problems and deficiencies, and then to develop programs to ameliorate them. Integration cannot succeed if special education teachers continue to view emotionally disturbed children as their only students. More thorough training of all school personnel is required on how to develop the specific techniques that will work in their individual situations if the spirit of PL 94-142 is ever to be realized. Inservice training must focus on developing a problem-solving process for each school, preferably a process that combines the skill development emphasis of the remedial approach to inservice training with the productive emphasis of the developmental or growth approach. Learning ways to identify specific problems and develop feasible plans holds much greater promise than the current practice of teachers utilizing partial solutions learned from outside sources at weekend workshops.

Inservice has always been a stepchild. The record of our commitment and achievement is less than enviable (Edelfelt & Lawrence, 1975; Meade, 1971; Davies, Note 4). The solution does not lie solely in more money being spent on inservice training. Rather, the solution lies in the understanding that inservice training is a major component of the total array of services provided by a school district in order to educate its children better. This understanding cannot be mandated. It must evolve in each district. The process of solution begins at each school and with a commitment by all of us that, with some help, each school can effectively meet its own training needs and solve its own problems.

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Alternative Living Arrangements for the Severely Behavior Disordered

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In the field of child care and development, it has been maintained that everything possible should be done to support "children at risk" in their family homes. Alternative living arrangements, however, have been both the context and process for treatment, training, and education for many children who cannot live in their family homes. For children with severe handicaps, access to alternative living arrangements is often essential.

The population of concern for this paper is the group of children having severe behavior disorders. These children exhibit one or more of the following characteristics in the extreme: unattributable learning difficulties, interpersonal relationship problems, aggression, depression, and other maladaptive behaviors, usually requiring intensive, long-term intervention of a specialized nature. Often these children are more commonly identified by labels—"emotionally disturbed," "learning disabled," "autistic," "autistic-like," "emotionally disturbed-mentally retarded," and "delinquent." It is not uncommon to find these children "in conflict" with their families, their peers, their school, and the general community, including the law. Also, it is not unusual for some or all of these organizational units to discontinue support and ultimately reject the child at some point in his or her career. Thus, when intensive assistance is eventually called for, it most often includes addressing the need for an alternative environment in which to begin treatment, training, and/or education of the child. The rationale for proposing an alternative living arrangement for children with severe behavior disorders must be backed by the fundamental principle that such an arrangement is in the best interests of the child.

Alternative living arrangements can include protection of the child, personal care, treatment, training, education, and in some instances, containment. The decision to place a child in alternative care can be based on any number of factors. Clearly, the specific needs of the individual child must be kept foremost in the decision-making process. In some cases, however, parental needs, that is, the parents' inability to nurture or cope with the child, may play a role. Some parents, of course, choose to relinquish care and custody of their child; and it is not uncommon for the state to remove a child from incompetent or abusive parents. Most frequently, the decision to place a child in alternative living arrangements results from the breakdown of an ecological system composed of the child's family, school, and community. The child may be in need of a specialized service that is not available to the home setting, the school, or even the community. A family crisis may arise in which the stability of the family is destroyed by the child's presence. This crisis could put the safety of the child in question insofar as the parents are rendered unable to provide the intensity of care necessary for the child to remain in the home. Child welfare authorities do intervene in such situations in recognition or anticipation of neglect or abuse.

It is not uncommon to find that home support services, such as child care workers, behavior therapists, and family support workers, required by families in the home to meet the needs of the child are unavailable or inadequate. Also, many families have found that service has been refused by a school, a homemaker agency, or a treatment organization as long as the child remains in the home. Hence, decisions to place a child into an alternative living arrangement must take into account not only the disorders exhibited by the child, but the capacity of the family and community to meet the child's needs satisfactorily in the family home (Hobbs, 1975).

Ideally, the child should be removed from his or her natural environment (i.e., the family home, community, and school) the least possible distance. The child should remain close to the people with whom he or she must learn to live and who in turn must learn how to increase their contributions to the child's development (Hobbs, 1975). Also, the separation of the child from his or her natural environment should be for the shortest possible periods of time. For those children who do not have families, it is critical to ensure that they maintain a relationship to the community and not simply to a service system. Mandatory periodic review of the status of the child who is put into alternative care of any sort is necessary.

Alternative care is sometimes necessary for children with severe behavior disorders. Unfortunately, many such children need specialized services that, at present, seem to be provided primarily in instructions. All too frequently, the classification and labeling of children with severe behavior disorders has functioned as a life sentence with confinement to a closed setting that is unwilling to or incapable of serving the child on an individualized basis. It is critical that community-based service systems demonstrate and develop alternative living arrangements in the most normal circumstances for those children who require intensive assistance.

Although many of these children have great difficulty meeting the demands of their natural environments over long periods of time, every effort must be made to prepare them for the return to their natural environments, particularly those environments in which they will be expected to live as adults.

Types of Alternative Living Arrangements

Historically, alternative living options for children with severe behavior disorders were limited to large state/provincial institutions. Outside of the family home, few, if any, programs were available in the community. In the late 1960s and the early 1970s, because of pressure exerted by parents and other children's advocates, a concerted effort by legislative authorities resulted in federal and state laws being enacted which sought to improve the quality of life for handicapped children. These laws required that educational programs be designed to serve the individual needs of each handicapped child within the least restrictive environment possible. The subsequent deinstitutionalization of state institutions had a considerable impact on the development of community-based services and programs.

Ideally, every family should have the availability of a variety of community service options for the child. Unfortunately, it is generally agreed that throughout the United States and Canada, comprehensive services, including alternative community-based living arrangements, are still the exception, rather than the rule.

Community-based living alternatives for children with severe behavior disorders include group homes, residential training centers, and family/foster homes. Contemporary models attempting to offer a more normal environment may provide a broader variety of physical settings, such as staffed apartments, duplexes, and condominiums.

The models described in this section offer a variety of living alternatives. The description of services is arranged in the order of most restrictive (institutions) to least restrictive (natural/foster home and respite services). The inclusion of the institutional model is presented not as a preferred or viable alternative, but with the recognition that, given that appropriate community-based resources were not available, families often have had no other recourse but to accept institutionalization of their children.

Residential Institutions

For the families of severe behavior disordered children, the institution has often been the only placement available for the child outside of the family home. With appropriate resource allocation, however, superior services can be offered from a community base.

Historically, the rationale for residential, institutional placement can be summarized as follows:

1. Due to factors such as severe aggression and physical assault to others, the child cannot be contained in a less restrictive setting.
2. The lack of appropriate services in the home community, such as outpatient assessment, crisis intervention, counseling, and appropriate educational services, necessitate institutional placement.
3. Pressure is exerted on families by law enforcement officials, professionals, and educators, to institutionalize their children (Appell & Tisdall, 1968).
4. Previous placement in an alternative community setting, such as a group home or residential training center, has been unsuccessful (Grosenick & Huntze, 1980).

In the institutional setting, the child receives total care within a self-contained community. The children live on locked or unlocked wards, depending upon their level of functioning and manageability. Different staff serve different functions. Ward attendants, nursing staff, and health care workers are the ward staff, who care for the children on a daily basis. These are the personnel who bathe, dress, feed, administer medication, and supervise the children. Professional staff, (i.e., psychiatrists, psychologists, teachers, and social workers) serve a rehabilitative function and often work in a separate building. The professional staff rarely see the children on the ward and may, in fact, have considerable difficulty in relating to the concerns of the ward staff. The involvement of professional staff with the children is frequently limited to the provision of medical, dental, and diagnostic services. Additional support service personnel, such as psychiatric counselors, speech and language clinicians, and occupational physiotherapists, may also be a part of the diagnostic and assessment team.

The children may or may not attend school, depending upon the severity of their behavior. For those who do, education usually consists of from two to six hours of instruction in the institution school. In some institutional settings, children on the open wards attend classes off the institutional grounds. Usually they are escorted to and from school by the ward staff. In other instances, they may be picked up by a school bus and taken to the community school.

Parental involvement is generally restricted to occasional visits in the waiting room or telephone calls to the ward staff. Frequently, geographical proximity determines the extent of parent involvement. If the parents live in a location within easy access to the institution, regular home visits may or may not take place.

As stated earlier, the central tenet of this paper is that all children, regardless of age or severity of disability, should have access to community services. It is hoped that as state and provincial governments recognize the ineffectiveness and escalating costs of the institutional model, existing financial resources will be diverted to community services.

Residential Schools

For the purposes of this paper, the term "residential school" refers to a private, not-for-profit residential educational program that has been specifically structured to meet the needs of a certain target group, such as children with autism, mental retardation, emotional disturbance, or other handicapping conditions.

Factors influencing residential placement may range from the inability of the family to provide adequately for the child to the lack of appropriate educational programs in the community schools. Frequently, the scarcity of alternate living arrangements, coupled with family breakdown and the inability of available community services to provide a highly structured environment are the determining factors in residential placement.

Typically, a residential school will house from 20 to 100 residents and provide a comprehensive, therapeutic educational program within its own setting. The children will live on-campus in dormitories staffed by house parents and support staff, attend classes in the school classrooms, and participate in recreational programs offered at the residential school. Within most residential schools a range of support services is available. Ancillary staff may include psychiatrists, psychologists, social workers, physicians, speech and language therapists, occupational therapists, and physiotherapists.

In addition to the individual goals established for the child in his or her family, the general goals of a residential school should include the preparation of the child for regular community-based educational programs and living situations, as well as preparation of the child to live as an independent, socially responsible member of society.

Most residential schools are operated by private, not-for-profit organizations and may or may not be subsidized by government funding. it is argued that the per diem costs for children residing in private residential schools is generally much lower than that in the state institutions. For example, the cost of housing a resident in a state institution in Pennsylvania in 1979 was $37,323, as compared to $16,050 for a private residential school in the same state (Barbour, 1980).

Currently, there is a great deal of controversy in educational circles regarding the merits of private residential schools for children with severe handicaps versus the provision of special classes in the community school with the child residing in an alternative setting to the family home. One of the arguments put forward by proponents of residential schools is that it is less expensive to serve large groups in a centralized setting than it is to serve small groups dispersed throughout the community. For example, it is suggested that the range of interdisciplinary services required by children with severe handicaps is so extensive that the quality of service would be drastically reduced if the children and services were not located in a centralized setting.

A second argument put forth is that residential schools have "trained staff" who are more capable of designing programs to suit the needs of the individual child than is the regular classroom teacher. A third argument is that the needs of children with severe handicaps are so unique that community schools lack confidence in providing an adequate educational program and in fact, often segregate the students (e.g., separate playgrounds, separate recess, separate lunch hour). Finally, many believe that children with severe handicaps in the community schools are treated as second-class citizens and are happier and better adjusted if they do not have to compete with their nonhandicapped peers.

On the other hand, arguments against residential schools suggest that we need to differentiate between short- and long-term costs and benefits to children with severe handicaps. Many believe that the long-term benefits of interactions with nonhandicapped peers in community settings far outweigh the short-term cost of the additional dollars necessary to provide age-appropriate curricula and adequate ancillary services in the community schools.

Second, adequately trained teachers do not require a completely segregated location in order to provide quality instruction. Observation of regular students in the community schools can, in fact, aid the special class teacher in developing age-appropriate curricula.

Third, regular education teachers benefit considerably from the opportunity to observe handicapped students enrolled in the community schools. It has been suggested (Brown, Branston, Baumgart, Vincent, Falvey, & Schroeder, 1979) that with the assistance of the special class teacher, skills such as individualized programming, adaptation of instructional materials and behavior management techniques can be more readily acquired when exposure to the handicapped students occurs on a daily basis.

Finally, handicapped children in regular community schools have innumerable opportunities to interact with their nonhandicapped peers in ways that are not necessarily of a competitive nature. For example, social interaction occurs in the cafeteria, during assemblies, and at traditional school events (Brown, et al., 1979).

Group Homes

Group homes provide a 24-hour intensive treatment model for those severely handicapped children who are unable to function in the natural or foster family environment. These homes provide suitable alternative living arrangements for many severely behavior disordered children, particularly those for whom extensive peer interaction in a home-like setting is desired. Group home placement has been successful with emotionally disturbed and mentally retarded children as a means for assisting in teaching cooperative living and for preparing them for less structured settings.

The preferred group home model described in this paper would serve no more than three to five children at any given time. Currently, there are growing concerns about group homes designed to serve more than this number. It is believed that group homes housing more than five or six children tend to reflect many of the problems of institutions cited earlier.

Group homes operate on either a houseparent or a three-shift-staff model and provide individualized programming to children in a structured family environment. Houseparent models tend to provide more consistent programming than shift-staff models. Problems of inconsistent approaches by staff on a shift basis can be overcome, however, particularly if the program operates on a data base and client review occurs on a regular basis. On the other hand, the "burn-out" rate for houseparents is usually higher than for professional staff who work on a shift basis. Common concerns expressed by houseparents are that they do not have sufficient time away from the children and/or they cannot rely on relief staff always being available when needed.

Regardless of the staffing model utilized (i.e., house parents or shift-staff), a coordinated approach between group home, school, and social agency staff is essential to ensure optimum levels of success in child performance and growth.

Frequent problems encountered by group home operators involve the lack of ancillary community resources and services needed to provide comprehensive programming. For example, in a survey conducted by O'Conner (1976), group home facilities indicated that vocational services, socio-recreational programs, mental health counseling, and transportation services were either inadequate or unavailable.

Gage, Fredericks, Baldwin, Moore, and Grove (1977) compared the costs of providing a comprehensive training program in two experimental group homes serving moderately and severely handicapped children with the cost of maintaining a child in the state institution. Their research indicated that the live-in parent model cost less than the state institution, whereas the manager-shift-staff model exceeded the state institutional costs. The changes in child performance and skill levels, however, clearly demonstrated that the long-term costs would be substantially less. "Any comparative costs, however, must be viewed not only in terms of projected long-term costs, which should be greatly reduced as the handicapped persons gain a degree of independent or semi-independent living and work skills" (p. 155).

Foster Homes

Foster homes can provide short- or long-term care to handicapped children who are unable to reside in the family home. Factors influencing foster place- ment may range from family breakdown to state intervention on the child's behalf, due to neglect or abuse.

There are two basic types of foster homes—regular or specialized. According to the British Columbia Federation of Foster Parents' Association, the goals for regular foster homes are far more general than those for specialized foster homes. For example, regular foster home parents are expected to provide the child with physical care, cognitive and emotional nurturing, guidance, supervision, and positive role modeling, whereas special care parents are contracted to design a specific program for the child which addresses: 1) personal and physical care and achievement, 2) behavior management and social development, 3) planned involvement with the natural family, and 4) community access to all necessary services and resources (FPA Policy Handbook, 1981).

In addition, the contractual arrangements for the two types of homes are significantly different. Regular foster home parents are paid a flat monthly rate for basic maintenance costs (e.g., food, clothing, personal needs).

Special care parents negotiate an individual contract with the respective social service agency for each child placed in their care. The contract covers the cost of food, clothing, shelter, personal needs, recreation, transportation, nurturing, and supervision. In both settings, medical care is usually paid for by the province/state, including the costs of any special prosthetic devices.

For the child with a severe behavior disorder, the regular foster home is not considered to be the resource of choice. The needs of this child can rarely be met by an untrained person, unless a significant support network is available. Foster home involvement with the educational system is usually similar to that of their natural family, in that the foster parents attend regularly scheduled parent-teacher conferences throughout the school year to discuss the student's progress and special problems in the school setting. Although foster families may have some contact with the school psychologist, speech therapist, and special counselor during the initial placement of the child, in most instances there is not a coordinated approach in programming for the child in the home and in the school.

With regard to other auxiliary services, home visits by the social worker are regularly scheduled to discuss the progess of the child in the foster home. In addition, depending upon the disability of the foster child, foster families may have regular contact with other support services, such as physiotherapists, occupational therapists, speech therapists, or child-counseling staff from the out-patient clinic of the local hospital or diagnostic centers.

Hostel or Respite Homes

The term "respite care" refers to a variety of programs which provide short-term relief to the families of severely handicapped children who continue to reside in the natural family or foster family unit. These services may range from providing in-home child care services to an overnight service in which the children reside in a respite home for a few days. Respite care is a particularly valuable service in that the availability of respite services is often sufficient to prevent institutionalization of the child.

Of the families referred to our own agency, the majority indicated that the unavailability of respite services for their children contributed to their decision to seek alternate residential placement. In each of the models presented in this paper, costs for respite care may be paid by the natural parents or the respective state/province social service agency.

In-Home Respite Services. This service utilizes a special-care or support worker who is contracted by a government social-service agency or private agency to provide up to eight hours of child care to the family of a handicapped child on any given day. This service is usually provided on a weekend when the child is not attending school, but may also be offered to a family during the school week when the mother may have to be out of the family home because of illness, or when a child is unable to attend a school program during the day. In this setting, the child remains in a familiar environment and is able to participate in his normal daily routine.

Some respite-care workers may also be asked to provide counseling and training to the family in management of the behaviors of the child or in developing social and recreational programs for the child in the home setting.

Private Respite Homes. Similar to a foster home setting, the private respite home provides relief child care to a handicapped child while the parents are away, or allows the parents a weekend off to spend more time with the other family members. In this model, state and/or private social agencies advertise and contract with individual families in the community to provide respite services. A social worker conducts a thorough study before the home is approved for respite care. Then a decision is made jointly as to what ages and handicapping conditions the respite family will consider.

Depending upon the agency and its financial policies, the respite family will receive either a negotiated monthly salary for a specified maximum number of children or a flat rate per day per child. In addition, allowances for transportation or recreational expenses may be considered if requested by the respite family.

Respite Beds as an Auxillary Service. Respite care is sometimes offered as a secondary service by specialized residential programs, group homes, or institutional settings. In each of these settings, a few beds may be made available to a specified population on weekends, when some of the facilities' children return to their natural homes for family visits. This type of setting offers more structure and services for the child who has severe behavior disorders or considerable physical care needs, and is often more appropriate than the private respite home in the community.

Parents and/or other agencies will usually arrange for regular placement weekends in advance. Some agencies may limit the number of weekends per month that the service is available to a particular family, thereby allowing more families to utilize the service. Other agencies may not impose these limits, and respite beds are made available on a first-come, first-served basis. Usually, respite children participate with the residents in all of the regularly scheduled activities, and staff have close contact with the families and social workers regarding an individual's "problem" areas or needs.

Respite Care Center. Respite care centers are funded to provide and manage a specific respite care program. The respective provincial or state government agency will contract with a not-for-profit association to provide respite services for a specific number of children. Parents may or may not be asked to contribute a minimal daily charge towards the cost of the respite care. Parents are usually referred to these settings by a social service agency or private association and have an opportunity to view the program before their child is admitted.

Respite care centers provide a variety of services ranging from placement of the child for a few hours while mother is shopping, to weekend care for family relief, or to an extended placement, which may last up to three or four months. The latter service is frequently used by families in which a major illness of the parent necessitates temporary alternate care or when social agencies require emergency placement for a child until he or she can be admitted to a foster home or group home setting.

The staff assigned to the residence on a shift basis may be comprised of trained child-care staff, teachers, or nurses, and may offer a wide variety of programs to the children. In addition, most respite centers will have a community medical center or physician available to them for emergency situations.

General Considerations, Issues, and Trends

In the last decade or so, the field of human service systems has experienced a tremendous period of growth and change. Our knowledge of historical developments and the present state of the art indicates that handicapped children should not be dealt with in isolation, but through a coordinated range of services. According to Wolfensberger (1973), there are at least four major attitudinal-ideological trends in society which are presently affecting the delivery of human services: 1) increasing realization that man can control societal processes, 2) universal acceptance of the principle of normalization, 3) movement from conformity to pluralism and a greater tolerance of deviancy, and 4) new vistas on prevention of handicapping conditions. He suggests that the significant changes in the educational system are a classic example of the attitudinal-ideological trends affecting one area of human service delivery. Education has moved from total exclusion of the severely handicapped through limited inclusion to the present total inclusion; from permissive legislation to mandatory legislation; and from inclusion of minimal problem children to inclusion of multiply handicapped children (Wolfensberger, 1973). Similarly, in the area of residential services, there is a movement away from large, segregated public institutions to a variety of community settings.

As mentioned previously, in the past the range of options for the families of handicapped children was often limited to keeping the child at home with minimal support services available or admitting the child to a public institution for total, often life-long, care. The movement away from institutional care and its dehumanizing practices has been, to a large extent, a response to advocacy and litigation by families of the children and adults who lived in the institution. Many of the private agencies presently offering a variety of living accomodations to handicapped children were initiated by these same groups of parents and citizen advocates who believed that each individual, regardless of age or handicap, had the right to live and participate in the community to the maximum extent possible.

Traditionally, community residential services have been made up of a number of separate, autonomous, uncoordinated agencies, each specializing in a particular disability or treatment milieu. Fortunately, within each agency the staff are often expected to provide for all of the needs of the child. If the child and family have additional needs that cannot be met by the existing agency, securing such services is generally hampered by the fact that the agency has neither the mandate nor the funding to seek out and secure them. Paradoxically, the parents also are hampered in their attempts to secure additional services because the child has now been placed in a given agency; therefore, the family no longer qualifies for services provided by other agencies. In reference to the length of time a child can remain in a specific resource, many agencies are bound by a "timeframe." The assumption is made that "x" number of years will suffice to rehabilitate the child. If the child has not been rehabilitated in the time frame allotted, the agency is considered to be at fault or the child is considered not treatable. The child is then passed on to another agency or placement, often with little or no communication between the two agencies. Unfortunately, movement from one agency to another without consultation or follow-up was, and still is, a natural phenomenon. All too frequently, the child becomes lost in the system, identified with as many labels as are required to secure a particular placement at a given time.

There is a growing recognition that unless community services are comprehensive in planning and development, they will deteriorate in much the same manner as have the large public institutions. Bogdan and Biklen (1981) suggest that the ultimate goals of a model service delivery system should include:

> (a) that services are provided as a matter of right to people who need them and not as a privilege; (b) that services are provided on a non-categorical basis, with disabled and non-disabled persons served together as much as possible; (c) that services are provided on a continuum so that people's needs can be met in appropriate and flexible ways; (d) that services be provided under the least restrictive and most normalized circumstances possible and (e) that agencies which provide services are accountable to their clients and to the society they serve. (Bogdan & Biklen. 1981, p. 60)

Recognizing that the child with severe behavior disorders may have a variety of needs that are unlike those of his peers, it is difficult to conceptualize alternative living arrangements without referring to underlying principles. The following principles have been developed with the assistance of Lou Brown and his colleagues at the University of Wisconsin, Madison (Brown, et al., 1979).

(1) *Future and Natural Environments*

The program into which a child is placed must focus on preparation for the demands of future, natural environments in which the individual will be expected to function upon leaving the program or becoming an adult. These environments are in the community and include domestic, vocational, educational, and leisure domains.

(2) *Adaptations to Enhance Access*

To compensate for various deficiencies in the repertoire of children with severe handicaps, it would be necessary to consider a number of strategies that will enable the individual to partially, or fully participate in activities. This could include (a) adapting materials, (b) adapting devices, (c) adapting skill sequences, (d) adapting rules, (e) adapting physical and social environments.

(3) *Chronologically Age-Appropriate Skills*

With respect to vocational, leisure and domestic skills, it is crucial that the child receive training in major life skills using materials and methods that minimize the stigmatizing discrepancies between children with severe handicaps and their non-handicapped peers. Interaction between these peers must be extensive.

(4) *Functional Skills*

The child needs to learn a variety of skills usually required to perform as independently and productively as possible in natural, domestic, vocational and community environments. For example, learning to use a food vending machine is more relevant than pounding pegs through a board.

(5) *Individualization*

For each child, individual programs for habilitation, education and plans for transition must be developed. It must not be assumed that a class or category of people (e.g., children with severe handicaps) or a group will always have the same needs in subsequent environments, or that they will function in exactly the same environments upon leaving the alternative living arrangement

(6) *Longitudinal Programs*

Plans for transition should be designed to prepare the child to the highest degree possible for functioning in the natural living environment that the child came from or a new environment that will be the natural environment for the child.

(7) *Transition to Adulthood*

It is critical in alternative living arrangements for children that recognition be given to the fact that children legally become adults at a certain age. Placements, particularly of older children, must be made with particular care. Age appropriate curricula and services are essential in order to prepare the adolescent for the shift into adult services. Consequently, placement of the adolescent in a setting where the program is designed primarily for younger children should not be considered as a viable alternative living arrangement.

An additional recommendation is made with respect to alternative living arrangements for children with severe handicaps in terms of work with families. That is, during the period when the child is removed from the natural family environment, it may be critical to provide extensive inservice and training to the family in preparation for the return of the child. It is equally important to ensure that the natural family is an integral part of the planning team regarding consideration of placement of the child in an alternative living environment. All too frequently, parents are made to feel that unilateral decisions are made by professionals without serious consideration given to the concerns of the family. It is important to point out that the rights and authority of parents can only be removed by the courts and not by human service professionals.

With these above considerations in mind, three service models presently available to the severely behavior disordered, the mentally handicapped, and the autistic are offered as working examples of appropriate community-based settings.

Current Models for Community-Based Services for the Severely Behavior Disordered

Youthdale

Youthdale Treatment Centres in Toronto, Ontario offer a network of services to behavior disordered youth and to their families residing in the greater metropolitan area of Toronto, Ontario, Canada. The youth range in age from 8 to 18 years. The Youthdale system is based on the philosophy that a viable human service organization must offer a comprehensive yet coordinated set of services whose ultimate goal is to allow the child to function in his or her normal setting.

The assumptions underlying the creation of the Youthdale services are that:

1. Disturbed children are often excluded from a particular program because of the absence of sufficient program elements in a given system.
2. Severely disturbed children require extensive programming for rehabilitation, but no one location can generate enough program elements to deal with the child effectively during the length of time necessary for rehabilitation.
3. Any system effective in working with severely disturbed children should have an advocate who promotes alternate placements, particularly less restrictive alternatives.
4. Alternate community placements are essential to movement from one level of intervention to a less or more intensive level of intervention.
5. Staff working with severe behavior disordered children require ongoing support and inservice training to increase their level of skill, reduce the possibility of staff burnout, and allow for upward mobility in the system.
6. Children will make progress if they participate in the decision-making process to the maximum extent possible.

Families and/or social agencies involved in Youthdale have at least four types of residential living options available to them, including a year-round wilderness camp program located in Northern Ontario, a group home in a rural community, and eight group homes, and two halfway houses located within a 10-block radius of each other in central Toronto. Additional service components include out-patient child and family therapy, crisis intervention services, and specialized educational day programs in the public schools operated jointly by Youthdale and the Toronto Board of Education.

Initially, all referrals for treatment are received by the Centre for Individual & Family Therapy (CIFT). CIFT is staffed by a director, one senior therapist, six therapists, an intake supervisor, a child-care worker, and additional contracted staff, including pediatricians, psychiatrists, psychologists, and educational consultants. The staff assigned to CIFT collect all assessment information and arrange further diagnostic assessments by the Youthdale medical and educational consultants. As soon as all of the necessary information has been compiled, the case is reviewed by the CIFT team and a decision is made as to whether the applicant requires out-patient or residential services and/or educational day services. At the time of intake, an advocate (primary worker) is assigned by CIFT to monitor the child's progress through the system.

As the advocate is accountable to the child rather than to any particular program, he or she serves as a "systems catalyst" in the sense that his or her major responsibility is the child and the child's changing needs through treatment. The advocate is expected to: 1) negotiate the treatment plan for the assigned child within the Youthdale network or with other agencies in the community, 2) stimulate additional services or programs where service gaps exist, and 3) act as the spokesperson for the child and family from the point of acceptance into the agency until discharge or until the child reaches maturity.

Residential Services. As mentioned previously, Youthdale provides a variety of living alternatives. These range from secluded containment settings to minimally supervised transition homes. Each setting is designed to meet a set of specific needs presented by severely behavior disordered children.

Wilderness Camp. The year-round wilderness camp program provides treatment to those severely disturbed children who require considerable containment and cannot function in the large urban setting. The staff, consisting of a supervisor, senior child-care worker, and cook-housekeeper, live on site and provide a highly structured outdoor work program to the 10 boys and girls placed at the camp.

Similar to the Outward Bound programs in the state of California and Province of British Columbia, the natural setting of the camp necessitates that the children develop interpersonal relationships and group work skills with their peers and staff.

Youthdale Rural Home. For those youth who are unable to deal with the pressures of the large city, or for those children who have previously been involved in the wilderness camp program and who are now ready for a less restrictive environment, Youthdale operates a group home in a small rural community. The group home, which utilizes a shift-staff model, has six to eight children in residence at any given time. These children attend the regular elementary or secondary school(s) and/or work in the local community.

Youthdale Treatment Home–Toronto. Youthdale operates eight treatment homes in the Toronto area. Each home is staffed by a supervisor, senior child-care worker, child-care staff, and housekeeper, who work on a shift basis. The staff in the home are accountable to a Program Director who is responsible for at least two or three homes. Each home provides differing degrees of structure and supervision to 6 to 10 children with emotional and behavioral problems. The children in these homes are grouped according to severity of disturbance and either attend Youthdale or special classes in the local schools. Movement from a highly structured home to a less structured home is decided jointly by the child, his or her advocates, and the group home staff.

Halfway Homes/After Care Houses. Youthdale operates two halfway houses in metropolitan Toronto for older teenagers who are on the threshold of independence. Both houses operate on a shift-staff model. Staff in these homes provide minimal supervision and assist the residents in cooperatively establishing house rules and decorum. The residents are fully responsible for daily maintenance of the home, including budgeting and all household chores. The six young adults living in each of the halfway houses attend regular or Youthdale classes in the secondary schools and work on a part-time basis. After discharge from the halfway house, these young people continue with the out-patient counseling services offered by Youthdale as required.

Youthdale Counseling Services. Youthdale counseling staff, consisting of social workers and child-care staff, work with children in need who are living within a family unit and within their home community. Children may be referred directly from Youthdale out-patient services or may be graduates of any of the residential components.

In addition to these services, Youthdale recently opened a crisis centre staffed by psychiatrists, nursing personnel, social workers, and child-care staff. The crisis centre program consists of a 24-hour-alert crisis team, a temporary crisis home, and a 10-bed, short-term psychiatric assessment unit.

The crisis team is comprised of six child-care staff who operate in pairs and work with the Toronto Police Department and the Ministry of Social Services. Calls come into the police department, which determines if the youth or family require immediate assistance. If so, the crisis team responds to the call. The team attempts to resolve the family conflict within the home or community setting. If necessary, the team will have the youth admitted to either the emergency crisis home for overnight stay, or to the psychiatric assessment unit.

The temporary crisis bed home is available to those youth who require overnight emergency placement. The home is staffed by child-care workers who provide counseling and support to children in crisis who require temporary accommodation. Typical children can be victims of abuse, drug overdoses, and intoxication.

The psychiatric assessment unit is staffed by a multidisciplinary team comprised of psychiatrists, social workers, and nursing personnel. Referrals to the assessment unit may come from the crisis team, social service agencies, or the courts. The length of stay ranges from 5 to 30 days, at which time children are admitted to Youthdale residential services or referred to other more appropriate service agencies.

Youthdale School Programs. Youthdale Treatment Centres, in cooperation with the Toronto Board of Education, operate six classrooms in regular public schools. Children enrolled in these classes may be from the various Youthdale facilities or may be residing with their natural or foster families, but are unable to attend the regular public school due to their intense behavior problems.

Each class is staffed by two teachers, one hired by the Toronto School Board and one hired by Youthdale. Remedial instruction is provided by the teachers hired by the Toronto Board of Education, and all additional services, including classroom support staff, family and child counseling, and community recreational training, are provided by the Youthdale teacher.

Youthdale Treatment Centres provide a continuum of services that are flexible to adjust to the changing needs of a child while preparing him or her for independent living in the community.

Community Living Board

The Community Living Board (CLB) was founded in Vancouver, British Columbia by the parents of residents of a large institution, Woodlands. CLB operates with the philosophy that each individual child or adult, regardless of severity of handicap, is best served in the home community, in circumstances that most resemble family arrangements. In addition, CLB maintains that each person can best achieve his or her potential through integration into the community social support system. CLB concentrates on expediting, purchasing, and then monitoring services to handicapped individuals and their families. It operates within the framework of the developmental model, which holds that every individual has the potential to grow and develop, given the appropriate supports.

The approach utilized by the CLB is called Individual Service Contracting, which evolved from the negotiations between the Woodlands Parent Group and the Minister of Human Resources. The Woodlands Parent Group felt that institutionalized residents, upon returning to the community, should have access to funds equivalent to the cost of their care in that institution. Further, they took the position that an independent agent was required to assist these individuals and their families in re-establishing their lives in the community, including finding their way through the service system. What has resulted is a model in which CLB acts as agent for a handicapped individual who has a "credit card" with a line of credit which, on the average, equals the amount of the cost of annual care in the Woodlands facility. The role of the CLB is to act as a service "broker" or case manager for the individual. As such, they assist prior to deinstitutionalization in identifying service requirements, developing comprehensive plans, and if necessary, services for meeting these requirements. They continue as a "fixed point of responsibility" following the individual's return to the community.

The Individual Service Contracting approach involves four major steps: Initiation, General Service Plan, Individual Program Plan, and Implementation and Evaluation. The process itself is not significantly different from any problem-solving or planning approach. The distinction, however, lies in the mandate provided by the government of British Columbia to the CLB to function as an agent that can arrange the purchase of services on behalf of institutionalized or potentially institutionalized handicapped persons. The four phases will be discussed briefly.

Phase I: Initiation (Referral & Intake)

Referrals to the CLB come from individual residents of Woodlands, parents of residents, Woodlands staff, and community agencies which have had contact with the individual who is in the institution or at risk of going into it. At the intake stage, the CLB works collaboratively with Woodlands staff and field staff of the Ministry of Human Resources. They complete a comprehensive assessment, focusing on the status of the individual resident in terms of assets and liabilities in the health, vocational and educational, social and recreational, and psychological and behavioral areas. Data for this comprehensive assessment are obtained by means of observation, tests, review of records, and a wide range of interviews with persons having direct involvement with the individual.

Phase II: General Service Plan

The General Service Plan is the planning stage. At this stage the comprehensive assessment of the individual is utilized in relation to specifying individual needs and the types of service responses that would address these needs. The General Service Plan is intended to establish a strategy for implementation and management of services in relation to the individual. It is most important that the plan focus on contingencies relating to the basic modules: 1) daytime programming (i.e., education, work training), 2) evening and weekend programming (i.e., recreation, household duties), and 3) overnight support system (i.e., support services required for overnight care).

Community living goals are established in collaboration with the individual and family, as appropriate. The service requirements to realize these goals are then articulated, with options and rationales for selection. A strategy and timeline in terms of immediate, medium-, and long-range steps outline how the plan is to be put into action.

Phase III: Individual Program Plan(s)

This stage is the most detailed and involves much joint planning with the individual, his or her family, various community organizations, and the institution. An Individual Program Plan is developed, which specifies clearly the expectations for all service providers, the individual, the family, the CLB, and any other individuals or groups that may be involved with the individual's community living. Included in the Plan is a specification of the living accomodations. The service contract agent, client, and family determine the most appropriate home setting for the client, based on his or her needs. Housing options may range from small group homes, foster homes, client-leased apartments, townhouses or detached homes in the community, to family care homes. Each Individual Program Plan must be as behaviorally specific as possible, and include measurement criteria as agreed to, particularly by those individuals or organizations supplying services to the individual.

It is important to point out that not all services outlined in the Plan will need to be purchased, as most individuals will be eligible for generic services. However, the Individual Program Plan(s) specifies a contractual agreement between the CLB, the individual and his or her family, and the service suppliers, regardless of how the service is provided.

Perhaps the most important item in Individual Service Contracting is the endorsement of the Plan and, to the highest possible degree, direction of the planning by the client, and his or her family. The CLB views itself in an enabling or assisting role with individual clients, and as such, does not want to be viewed as a prescriber of programs. Trained parent advocates from the Woodlands parent Group are available to assist the individual and the family in all phases of service contracting to ensure their input and understanding.

Phase IV: Implementation

Following completion of the Individual Program Planning and the contractual arrangements with service suppliers, the CLB has responsibility for obtaining the full approval of the Ministry of Human Resources for the Plan. Upon receiving this approval, the Ministry then makes arrangements for payment to the suppliers (i.e., for housing, training, recreation). The CLB then begins the ongoing coordination of the plan. This coordination includes systemmatic review of each individual's situation and progress.

In summary, the Individual Service Contracting approach, as described here, was developed by parents of institutionalized children and adults, to ensure that the handicapped individual is not denied services because of lack of agency coordination. Too often service plans have been based on availability of resources and/or eligibility criteria that do not take into account the unique nature of an individual's status. In this respect, it is anticipated that the Individual Service Contracting approach will require that the service "agent" or "broker" make innovative arrangements for alternative living situations and other services, while encouraging some service organizations that have never served handicapped people to open their doors in an entirely new fashion.

Gateway House Society

Gateway House Society, located in Delta, British Columbia, provides treatment for autistic and autistic-like adolescents, aged 12 to 19, living in the Province of British Columbia.

The Society holds the philosophy that treatment, training, and education of handicapped children, regardless of severity of disturbance, should be provided in the least restrictive environment. To the maximum extent possible, the Society attempts to utilize existing generic services in the community. Further, the Society maintains that an interdisciplinary approach, based on the active participation and collaboration of parents, Gateway staff, consultative personnel, and community volunteers, is essential to meet the changing needs of the adolescent and his or her family.

Referrals to the Society come from parents, schools, social workers, and diagnostic assessment facilities affiliated with the major hospitals. At the intake stage, the client's social worker or educational consultant prepares a comprehensive assessment, including recent psychological, psychiatric, educational, and social reports. After a site visit is completed by Gateway staff, the application is then reviewed by an Admissions committee, including a psychologist, psychiatrist, representatives from the Departments of Education and Human Resources, and Gateway personnel. A decision is then made as to whether the client requires residential or day services.

Originally, Gateway House came into existence as a 24-hour residential centre designed to provide intensive treatment and vocational training to 10 autistic adolescents. Subsequently, additional components were added so that today the program now functions in three main areas: residential, community, and day services.

Residential Services

Families residing in the Province of British Columbia are eligible to apply for residential services for their adolescent sons or daughters. Gateway presently offers two types of residential services. The residential centre accommodates up to 10 adolescents and is available to the most seriously disturbed clients. In addition, Gateway supervises a number of two-client teaching homes available to adolescents who are able to function in a less restrictive environment.

The residential centre is situated in a small community within driving proximity of a large urban area. The adolescents live in a large three-story home located within walking distance of the downtown shopping area, secondary school, and community recreational facilities.

The residential centre, which utilizes a shift-staff model, provides a structured teaching environment emphasizing life skills and vocational training, as well as academic and recreational programming. The adolescents either attend classes at the local high school or day classes offered at the residence. The centre is staffed by trained child-care workers, two senior staff, a cook-therapist, night-housekeeping staff, weekend supervisor, and relief staff.

A voluntary Board of Directors, which oversees all of the services offered by the Society, is comprised of 12 members of the local community who meet once monthly with the Program Coordinator and Administrative Assistant. As well, there are a number of committees of the Board which provide direction and input to the organization and promote public awareness within the community.

For those youth who do not require the intensive treatment provided in the residential program, or for those young people who have completed the residential program but still require a higher level of care than that afforded by the general community, Gateway House Society supervises and monitors the two-client teaching homes. These homes are staffed by teaching parents who are extensively trained by Gateway personnel. The teaching parents are trained to meet the physical, emotional, and social needs of the child assigned to their care; to perform the nurturing functions normally provided by the child's parents; to provide a homelike environment; and in consultation with the Assistant Coordinator, to develop an individualized program plan addressing the domestic, recreational, general community, and vocational domains.

The adolescents in these homes attend the Gateway school programs during the day and participate in the work experience settings in the local community. In addition, the teaching home parents are provided with a part-time child-care worker who assists in teaching recreational and community skills after school and on weekends.

Community Services

An additional service provided by Gateway personnel is to assist parents and child-care workers who are hired by the Ministry of Human Resources to work with the child in the family home. Parents and child-care staff are taught instructional strategies designed to elicit and maintain appropriate behavior and daily life skills. They are also encouraged to participate in a three-week intensive training program offered at the centre. In addition, regularly scheduled home visits are arranged to provide ongoing assistance and support.

Gateway School Program

Gateway House Society, in cooperation with the Delta, British Columbia School District, provides an educational program to the residents of the centre and teaching homes as well as to day students residing throughout the lower mainland who are unable to attend classes in their home school district. Classes are offered at the local secondary school as well as at the residence Monday through Friday, 12 months per year. Instruction is provided by two teachers and three teaching assistants hired by the Delta School District and by the child-care staff employed by the Society. The instructional strategies in use are based on an approach that is directed at reducing or eliminating the maladaptive behavior, assisting in developing a new repertoire of behaviors, including communication, the ability to stay on task, socialization, and academic and vocational skills.

The Gateway training program consists of three phases: Intake and Assessment, Pre-Vocational and Vocational Training, and Job Training and Community Placement.

Phase I: Intake and Assessment. At the time of intake the Gateway school and child-care staff assess the student's behavioral problems and develop appropriate management techniques. In addition, they assess the student's level of functioning in all developmental areas and in consultation with the family, design an individualized program plan that includes individual student needs, instructional methods, and measurement criteria for success.

Phase II: Vocational Training. Phase II consists of determining what future jobs are available to the handicapped student in his or her own community. As well, the staff determine what requirements are necessary for entry and successful employment in these facilities (e.g., sheltered workshops, light industry). Taking into consideration the student's strengths and weaknesses, staff then determine which prevocational and work experience programs offered by the Society would be most able to maximize successful re-entry of the student to his or her home community. In addition, the staff determine what behaviors are necessary for the adolescent to compete successfully in a particular job placement (e.g., on-task behaviour, ability to work for long periods without prompting, minimal disruptive behaviors).

Phase III: Job Training and Community Placement. During the third phase the adolescents spend the majority of their time in work experience programs in the surrounding community, with preference given to those work sites similar to what is available to the adolescent in his or her home community. This phase also involves extensive participation in appropriate community activities, with strong back-up supports provided by the Gateway personnel. During this period consideration is also given to seeking an after-care placement in the adolescent's natural community or referring him or her to one of the teaching homes supervised by Gateway Staff.

The long-term goals and objectives of the Gateway socio-educational program include assisting the adolescents in developing their skills in the home, school, employment, and general community domains. The following section delineates the basic content of each of the program components.

Domestic Domain

Self-help and home maintenance skills are taught on a daily basis, including meal preparation, housework, laundry, simple budgeting, and routine life skills.

Recreation and Leisure Domain

A variety of recreational activities are taught at the residence, (i.e., board games, cards, music, television, crafts). Within the community, the students are taught to utilize local facilities with minimal supervision, (i.e., swimming pool, library, bowling alley, skating rink, recreation centre, amusement centres). In addition, regularly scheduled recreational/leisure activities offered at the high school to the general student body are also available to the Gateway students attending the high school program.

General Community Functioning Domain

All students are provided opportunities to utilize the general community. Individualized and group instructional strategies are employed in teaching community awareness. The students are taught how to access and use public transportation, shopping centres, restaurants, postal services, hospitals, banks, and so on.

Employment/Vocational Domain

The students are involved in an extensive pre-employment program in a variety of heterogeneous work environments. Initially, the students are taught sheltered workshop skills such as collating, folding, sorting and matching, bagging, weighing, assembling, measuring, woodworking, and maintaining greenhouses. Subsequently, they are also offered extensive opportunities in the local business community in a variety of work experience settings such as janitorial services, lawn and garden maintenance, assembly-line work in local industry, cafeteria and food services in restaurants and hotels, laundry and maid service in hotels, clerical and laboratory work in the local hospital, and pricing, bagging, and stocking shelves in local retail stores.

In summary, the following factors have been influential in stimulating and guiding the development of the present range of services offered by Gateway House Society.

1. The presence of a strong commitment to develop a community-based program shared by parents, professonals, and Gateway staff.
2. A strong commitment to the underlying principles of normalization.
3. A commitment to involving and demanding the participation of various community interest groups, including the business sector (work experience programs), private service groups (capital projects, public awareness and volunteers), and education and social services (funding and provision of staff and materials).
4. A commitment to the ongoing monitoring and evaluation of client progress, based on extensive, objective data collection.
5. A commitment to the ongoing supervision, monitoring, and evaluation of the personnel and total service delivery of the agency.
6. A commitment to the belief that a viable service system must be open to developing or seeking out as many services as are required to meet the unique needs of each handicapped individual placed in its care.

Summary

This paper has presented an overview of existing models of alternative living arrangements for severely handicapped children. The authors have described, in some detail, three existing models that provide a network of services, including alternative living arrangements, offered in community settings. The models described are characterized by a variety of living arrangements, behavioral assessment and placement, intensive socio-educational training programs, individualized transition plans to prepare for subsequent community environments, and extensive use of existing community resources. Recognizing that severely behavior disordered children frequently require alternative living environments in order to access essential services such as education, treatment, and/or specialized training, it is vital that the pathway into and out of the living alternative be clearly defined, and that safeguards for the child, including external advocacy and monitoring, be incorporated at the time of referral. Care must be taken to ensure that the separation of the child from the natural/foster family occurs for the shortest possible period of time in the least restrictive environment.

For those children who do not have families, it is important to ensure that they have a relationship to the community and not simply to a service system. In this regard, comprehensive individualized planning is essential for every child requiring alternative care. That is, community-based programs must be designed to fit the needs of the individual child, rather than expecting the child to fit the needs of an existing program.

In conclusion, parents and professionals must work together to lobby for the development of appropriate quality services in community settings. A comprehensive network of services for severely behavior disordered children, including alternative living arrangements, should no longer be considered wishful thinking. The models and the technology are already in existence.

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Parenting the Emotionally Disturbed Child: Personal Perspectives

Edited by Margaret M. Noel

Since the early 1970s, there has been increasing recognition of the role and responsibilities of parents in the educational process. What was first an acknowledgment of the need for parental involvement became, with the passage of PL 94-142, a mandate. The professional literature is replete with articles and books on how to work with parents, how to educate parents, and how to mobilize parents as advocates. Relatively little, however, has been written by parents for professionals. In particular, there has been little written about the experiences of parenting a handicapped child.

Both Volumes 1 and 2 of this monograph have discussed the problems and issues related to providing quality educational services to emotionally disturbed children. A number of recommendations have been made, and in general, there has been consensus regarding the difficulties faced by educators who plan programs for these children. In addition, the need for parental involvement consistently emerged in the recommendations. However, the editors felt that these monographs would be incomplete without a chapter that addressed parents specifically. Furthermore, we felt that rather than professionals presenting a discussion of parenting, we would ask parents to present their side of the story—their perspectives of the education system. What follows, then, are two case histories, edited from interviews with the parents of two emotionally disturbed children.

The particular parents were selected based on their geographic location as well as the ages of their children. One parent was referred by a professional who had worked with her child; the other parent was referred by an advocacy group. The fact that the frustrations and dissatisfactions are similar is coincidental. No deliberate attempt was made to present only the irate or activist parent, and while we certainly cannot say that these parents represent all parents of emotionally disturbed children, it was apparent throughout each of the interviews that there were other parents facing the same, if not worse, difficulties in their attempts to secure quality educational services for their children.

At the request of the parents, anonymity has been protected. The reason given, in both instances, was to protect the children. From this editor's perspective, there was recognition that there is another side to each story. The intent was not to indict schools or professionals; however, as these latter individuals have had an opportunity to present their perspectives, so too have the parents.

Debbie: "A Typical ED Child"?

Debbie is 15 years old and currently lives in a private residential facility for emotionally disturbed children. Her history is marked with a number of placements, including both special and regular education settings. Her parents and brother reside in a large, suburban upper-middle-class community on the East Coast, reputed to have an excellent public school system.

Debbie's mother described her daughter as "a typical disturbed child" in that her behavior was, and is, totally unpredictable and inconsistent across program placements, management plans, and individual people. Despite the behavioral extremes and the learning problems, it was difficult for anyone to diagnose Debbie's problem. Her mother felt that something wasn't right by the time Debbie was two years old. For example, according to her mother, Debbie never crawled. At eight and one-half months, she reportedly just stood up and walked. More noticeable were her severe temper tantrums and extreme activity. As her mother says, "She was into a lot of things and had to be closely watched." Debbie was adopted at three months of age, and no prenatal histories were available. Therefore, while Debbie's mother saw some unusual development problems, there was no reason to suspect that anything was really wrong with her daughter.

Debbie's Case History

At age three, Debbie was enrolled in a neighborhood nursery school where her behavior and motor problems soon became apparent. Debbie was clumsy; she also bit other children. The children quickly learned to avoid her, so that Debbie was basically socially isolated for the two years she managed to stay in nursery school.

At age five, Debbie entered a public school kindergarten and quickly became a major management problem. Although she had been toilet trained for several years, she began to wet the bed and herself almost daily. This daily enuresis was to continue until Debbie was 13 years old. Debbie was also distractible, had a short attention span, and her clumsiness increased. The tantrums intensified, but only at home, and when Debbie's mother tried to talk to the kindergarten teacher, she was told to "just get on Debbie more."

In first grade, Debbie was referred to the reading specialist for evaluation because of problems in reading and math as well as for her motor problems. The reading teacher felt that Debbie had a "minor'" perceptual motor problem, but recommended no follow-up or special assistance. Neither Debbie's regular teacher nor her reading teacher saw any problem. Debbie was "a sweet little girl in school." Her mother, however, reported that Debbie was "totally unmanageable" at home.

The home behavior intensified during the next two years, and Debbie spent hours having tantrums. She practically had to be dressed by her mother and frequently was carried to school. Her academic performance in school was slipping, but the school did not consider her far enough below her peers to warrant an evaluation. Again, there were no behavior problems in school, although Debbie was considered withdrawn and had no friends. The school told the mother that Debbie's problems, if they even existed, were due to "problems in the home," and that the mother was not managing Debbie well, and was too neurotic.

As Debbie's home behavior became more violent, she began to break things and punch holes in walls. Her mother became more adamant about having an evaluation. She went to Debbie's pediatrician, who told her that she needed to provide a more structured and controlled environment with time schedules and definite limits. At times Debbie would respond to the new limits, but at other times she would have an unprovoked major "blow up."

Her mother began to feel more and more insecure about her own parenting ability. "Everyone, even my own mother, felt that it was my fault. No one saw a problem. Finally, I said to my husband, "If it's me, I need to know." The parents contacted the pediatrician, who in turn recommended a private psychologist. Thus, at age eight, Debbie had her first psychological evaluation.

The psychological examination revealed a below-average IQ, which was considered inaccurate. Other test results led the psychologist to recommend a complete neurological exam. The sum of the evaluations was that the psychologist and neurologist agreed that Debbie was a "multiproblem child" who had definite signs of organic brain dysfunction and significant signs of a psychomotor seizure disorder. In addition, she was probably learning disabled. Debbie's mother said she was unsure and confused by all the tests and diagnoses, but "I was looking for anything that would stop the tantrums."

The parents had paid for both evaluations, but they decided to have a private educational evaluation through a local private special education center. The educational evaluation revealed that, at age eight, Debbie could neither spell nor write any letters past E. She was also functioning below the kindergarten level in reading and math. The evaluator felt that Debbie had developed highly refined coping skills and had managed to "cheat" or copy from her classmates. Furthermore, he felt that Debbie's IQ was probably above average, although she seemed to have some memory problems.

Armed with all of those test results, the parents confronted the public schools. Debbie was now at the end of third grade, and her parents wanted her retained at her grade level, but placed in a small, highly structured classroom and provided with tutoring. The public schools could not provide such a program, but agreed to an out-of-district placement in a private, albeit not special school. The parents accepted the placement and agreed to pay for the additional tutoring. At this same time, Debbie was placed on medication, initially Mellaril, and her parents began to send her to a private psychologist.

The first year at the new school, a repeat of third grade, basically went well as Debbie made some academic gains. But the social isolation remained, and the tantrums at home continued. Debbie had more EEGs done, each one showing some abnormal spiking, and medications were changed. Debbie's fantasy life, always present, became more apparent. She talked to herself often and began to play with things like garbage and scraps of paper. According to her mother, Debbie retreated more and more into her own world.

By age 10, after two years in the private school, the pressures began to show. Debbie's home tantrums increased markedly in frequency and intensity. Debbie's private therapist recommended special education, so her parents returned to the public schools to seek a special education placement. PL 94-142 was not yet in place, and there were no state guidelines for placement. The only program for emotionally disturbed children in Debbie's school district was in a special school, and the school officials did not feel that Debbie had severe enough problems to be placed in the special school program. Not accepting the private psychological evaluation, the school requested their own psychological and educational evaluations, both of which agreed with the prior findings.

Thus, at age 11, Debbie was placed in the fifth grade class in the special school. The school staff immediately began to say that Debbie did not belong in the school and wanted her transferred to a regular public school program. However, the mother felt that Debbie was making progress and seemed to want to stay in the program; the parents resisted the transfer. "The staff kept telling us there was nothing wrong with our child. We alienated everyone at the school at this time. Teachers placated me and said they were intimidated by me or couldn't deal with me."

At the time that Debbie entered the special program, her mother began to attend parent groups run by a social worker on staff. Gradually, the mother reports, this social worker began to agree with both Debbie's mother and her private therapist about the seriousness of Debbie's problems. "She (social worker) kept telling the rest of the staff that she had observed Debbie and worked with me, and the problems were real—complicated and subtle—but real."

Debbie completed the year, attended summer school, and returned to the special school the next year for sixth grade. By this time, Debbie had matured sexually and by her mother's account was "gorgeous . . . a beautiful girl." She was placed into the sixth grade with 39 emotionally disturbed boys and no other girls. Her parents became concerned and asked about other placement options; they even contacted the superintendent of the district. The school's response was to do a computer search to find another girl for the program. None was found, however, and Debbie remained in the program.

By mid-year, Debbie began once again to deteriorate. Her academic progress began to slip and she continued to have no friends. Again, the violent home outbursts intensified, and Debbie began to refuse to go to school. Debbie's therapist felt that this pattern—one year of success followed by a deterioration in the second year—was due to the stress Debbie created for herself by trying to maintain an image as a good, compliant student.

In early January, the parents and the school met to discuss a placement for seventh grade. The school wanted to place Debbie in a partially mainstreamed program in a junior high school. The parents were concerned because, once again, Debbie would be the only girl in the program. They were also unsure of the amount of instructional time Debbie would receive, so they began to look at private schools with learning disabilities programs.

Debbie's outbursts at home were becoming more violent and destructive, particularly over the issue of going to school. One morning in the spring of that year, Debbie became particularly upset over having to go to school. She painted the floor with fingernail polish, overturned furniture, broke the telephone, and then attacked and bit her brother. When the distraught mother arrived at the school with her daughter, she happened to be met by the social worker who directed the parent group. Debbie's mother said that her account of the destruction and the violent outburst was met with the usual disbelief and suspicion. However, this time the social worker asked Debbie's mother to take her home and show her the damage. The social worker immediately went back to the school and began to advocate for Debbie's placement in a small, structured school environment, and confirmed the descriptions the parents had previously given.

By the next fall, PL 94-142 was in effect. The parents refused the junior high placement and requested alternative placement in a small local private school. The mother reported that the placement decision was made with no IEP meeting and that an IEP was sent to the parents for signature. Furthermore, there had been no multidisciplinary team evaluation.

Frustrated, the parents placed Debbie in the private school and then entered into administrative Due Process. At the review stage, the school began a thorough investigation into the family and home. The social worker was not allowed to testify, as she was considered too pro-family. The principal of the special school that Debbie had attended tried to convince the public schools to provide the money for the alternative placement. The psychologist who testified for the school district had never administered any tests to Debbie, nor in fact, was she certified as a child psychologist. According to actual records, she was a former psychiatric nurse who had no experience in child psychology.

Despite the testimony of Debbie's private psychologist and the support of professionals who had worked with Debbie, the county held firm, stating that "the junior high program is best for Debbie because her problems are not severe, and besides she is used to being the only girl among classes of boys." The parents lost at the first-level hearing, appealed for a state-level hearing and lost again. The mother reported that it cost the family $10,000 during that year for tuition, therapy, and attorney's fees. However, Debbie had done well in seventh grade and things were much calmer at home.

At the end of that year, the parents once again went to the public schools to discuss an eighth grade placement. Because things were going well, they wanted Debbie to remain in the private school, so they requested a full reevaluation. The school agreed and said they would have their "two top people" conduct the evaluation. This evaluation supported the parents and confirmed previous findings of neurological impairment and serious emotional disturbance with some learning disability. According to the mother, the whole attitude of the school people changed drastically after this evaluation. "We weren't treated like a plague anymore. The school was almost contrite."

An IEP meeting was held, the first ever, and the school offered placement in a learning disability program—reportedly against the advice of the teacher. The parents refused this placement and were prepared to ask for another hearing. Two weeks later, however, the public schools, without explanation, agreed to provide for an out-of-district placement in the private school for one year only.

Thus Debbie, who was then 14 years old, began the eighth grade at her private school. However, all did not end well. In November the deterioration began again. Debbie's school behavior became worse, and she spent days at home crying, screaming, and begging not to go to school. The parents persevered until her therapist suggested hospitalization because of Debbie's "suicidal thoughts and wishes." The private school and the therapist recommended that Debbie be taken out of the program.

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This time the public school responded quickly. They ordered a placement meeting immediately and recommended residential placement. Debbie remained at home until May while her parents and the public schools investigated residential options. Debbie was placed in an out-of-state residential program at public school expense. She has remained in this program for a year. Her parents feel that she is doing "OK," although there are still outbursts. She is making friends for the first time; however, she is not without problems—when she was home during her first vacation, she experimented with drugs and alcohol. In addition, although she was unlicensed, she took the family car without permission.

The family does not know what the future holds for Debbie or for them. They call her "a blessing in disguise" because they feel the family is stronger because they have had to work to survive. The mother also feels that it is only sheer luck that her older son, also adopted, is not on drugs, angry, or alienated. She feels that he lost out on much. "Debbie consumed our entire time and energy. We had to control her, get her to school, take her to doctors."

Although there is currently complete agreement and cooperation among the parents and the public school, the parents still feel angry about what they had to go through to secure appropriate services for Debbie. The mother wishes that they would have believed her or trusted her instead of trying to prove her wrong. She said the years of guilt were debilitating, and through it all, the schools never looked at the whole situation, never attempted to investigate the problems. "They just assumed the problem was with us." Early on, Debbie's therapist told the parents that the only reason that Debbie was maintained in school and at home for so long was because of their support and effort. Lately, several other professionals have told the parents the same thing, and this has been reassuring.

When asked to make recommendations for improving parent-school relationships, Debbie's parents had strong opinions. The most important factor they cited was the need for emotional support. In particular, they mentioned the need for school staff to be trained to communicate with parents. School staff need to describe the problems or situations thoroughly, they need to be explicit about how they will deal with the problem, and they have to help the parents understand. The parents felt that the administration, in general, was unsupportive, but even worse, none of the teachers showed any understanding of Debbie or the complexity of her problems. They report that,

> All the teachers knew was behavior management. They focus on tantrums and acting out. They don't recognize tension, stress, or emotional states in children. The principal of Debbie's first elementary school once said to me that if she had thrown bricks they would have helped her.

According to Debbie's parents, a second major area that needs improvement is advocacy. They feel that the public schools should have someone on staff who can serve as an advocate, or at least objectively represent the interests of the child. This person should be someone who is not immediately involved with the child, because it is too difficult for teachers and administrators to deal with errors or suggest reevaluations. Also related to advocacy, Debbie's parents stressed the need for educating parents about emotional disturbance, to remove the stigma and the guilt. Furthermore, parents need to develop communication skills and need to know what to ask of the schools.

In summary, these parents feel that the key to success is for parents and schools to refocus their energies from fights and confrontation to active cooperation and equal participation in children's education.

Michael: "The Multiple Problem Child"

Michael, an only child, is 11 years old, physically healthy, intelligent, and is described by his mother as having a loving, generous, friendly, and inquisitive nature. He lives in a major city in the southern United States. He appreciates art, nature, architecture, history, and is a lover of books. He has an appreciation of and talent for music and plays the piano both for therapy (he is in music therapy) and for pure enjoyment. He has coordination and perceptual problems for which he receives occupational therapy.

Michael is described as fearful, anxious, nervous, timid, and having low self-esteem. He deals with these feelings by being bossy, by taking on the role of an adult (which alienates his peers), and occasionally by being aggressive. He is emotionally immature. When upset, he becomes verbally abusive. He falls apart, cries, hides in a corner and brings more negative attention to himself. Mike has been diagnosed as having emotional disturbance (childhood schizophrenia), minimal brain dysfunction, hyperactivity, soft neurological signs, learning disabilities, visual-perceptual and motor handicaps, and multiple handicaps.

According to his parents,

> Mike shows great courage each day, meeting the challenges even when the fear inside of him is at fever pitch. I have seen him face summer camp (an ordeal for him) day after day, knowing he would be taunted, knowing that he would have to face a swimming pool full of unruly boys and the ever-present bully ready to ridicule and torment. But he faces these nightmares at school, camp, scouts, and Sunday school again and again and manages (after the initial anger wears off) to keep a charitable heart for the ones inflicting pain. Last summer he was excluded from the second semester of camp because he hit one of his tormentors. It was a disappointment to be excluded after one and a half summers in a "normal" summer camp, but it was also a relief for us because he was spared the ordeal for the rest of the summer. We are deciding now about how he will spend this summer. His therapist feels, and we agree, that he needs exposure to other children and he needs to learn to manage his fears and handle his own problems. My heart aches when I think of what he goes through, but I know that someday he will be alone and will have to manage without our protection.

Mike does well academically and has the potential for superior academic performance. He has even been called "brilliant" by his teachers and by most of the people who have tested him.

Mike's Case History

Mike's mother reported that as an infant, Mike was alert and happy. Soon, however, little things began to disturb her. Mike was slow in turning over in bed, in sitting up, in crawling and in walking, but mostly he was extremely slow in talking. He did not speak until he was three, except for a few words that he mimicked. He did not initiate speech. Mike's mother repeatedly brought these delays to the attention of Mike's pediatrician and was told that he would "just grow out of it." She explained how Mike was not talking, how he looked through you when you were talking to him, how he banged his head, how he could not tolerate high pitched sounds like the vacuum, and how he was oblivious to other sounds. She also described his hyperactivity and the fact that she was insulted by every one of the nurses when Mike did not respond to their commands during office visits. When the pediatrician did not make any suggestions or diagnoses, Mike's mother became persistent. Finally, she was referred to a local speech and hearing center for evaluation.

The evaluation was incomplete because Mike was "not cooperative," although his hearing seemed to be normal. However, Mike was plagued by high fevers and ear infections until he was three years old, at which time drainage tubes were placed in his ears.

Mike's mother still considers that the pediatrician was a fine doctor who was just ill-equipped to recognize early signs of emotional disturbance and perhaps a little afraid of and repulsed by Mike's behavior. However, after three-and-a-half years of wondering, Mike's mother struck out on her own. She wrote to Closer Look and began reading their newsletters, pamphlets, and other materials. These led her to other sources. She has compiled two file cabinet drawers and several boxes of indexed information on organizations, legislative actions (and in some cases inactions), programs, books, laws, and research on the subject of emotional disturbance and learning disabilities. Despite her efforts, Mike's mother could find no programs or local information sources which pertained to children Mike's age.

Finally she contacted the Director of the Developmental Disabilities Department at a local university medical center. The program was new, but the Director was very helpful. "I spoke to her about Mike's delayed speech, immature behavior, and other symptoms. She really seemed to understand and was not shocked or did not recoil—my hopes soared."

The evaluation at Developmental Disabilities was a drawn-out affair with appointments scheduled weeks apart with professionals from different disciplines. Mike had physical, dental, psychological, opthamological, and hearing examinations. He was given an educational evaluation and others that his mother cannot recall. The educational evaluation was the final appointment, and when it was over the examiner told his mother that Mike was learning disabled, not retarded (which she had feared) and was, in fact, very bright. A few weeks later, the parents met with the staff psychiatrist, who provided an interpretation of the evaluation.

The parents waited some time for the psychiatrist, who, when she arrived, had forgotten to bring any of Mike's test results. She gave the parents some general comments and diagnosed Mike as hyperactive and learning disabled. The sole recommendation was that Mike be seen by a social worker.

> She answered none of our questions adequately. We were given nothing in writing—no reports. Her attitude was one of superiority. She made us feel somehow at fault, but she did not explain how. This was our first encounter with such an attitude, but it has certainly not been our last.

During the next year and a half, Mike was seen by a social worker. He was never given a next appointment. Each time, his mother had to call and convince the secretaries that the situation was serious and warranted an appointment. The appointments were always one to two months apart. The parents were never asked to talk to anyone about their feelings and were ignored or placated when they asked questions. Again, Mike's mother is not bitter. She feels that the social worker was a caring individual, but just did not understand Mike.

Later that year, when Mike was four, his pediatrician advised his parents to enroll him in a nursery school, hoping that contact with other children would help. After a month Mike was excluded from that nursery school for pushing other children who tried to make contact with him. The parents immediately enrolled him in another nursery school. The owner of this school, according to Mike's mother, was an intelligent and compassionate woman who understood children. She had patience with Mike and helped him a great deal. She worked with the Developmental Disabilities staff and, when Mike was evaluated, she was allowed to sit in on the staffing. The parents, however, were not allowed to attend. This exclusion would be encountered again and again. At the staffing it was decided to put Mike on Ritalin. He took the medication for about a week until his parents were called to the nursery because Mike was standing in a corner, glassy-eyed, frightened, and completely out of contact. Since that time, the parents have been told that Ritalin was totally inappropriate for Mike; they are grateful that they threw it away before it harmed him.

At this same time, the nursery home owner recommended that Mike's parents consult with another psychiatrist who was a friend of hers. This psychiatrist observed Mike in the nursery school and informed the parents that he was badly in need of help. He referred them to a church-affiliated social service clinic where he consulted, as the parents could not afford his regular fee, and prescribed a tranquilizer, Mellaril, for Mike. He accompanied Mike through the intake process. For the next two years Mike was seen by a social worker at the clinic twice a month. Again the parents were excluded and had only two meetings with the social worker during the entire time.

It was during this time that Mike was diagnosed as a "childhood schizophrenic." However, the parents were never given an explanation of the term. The mother, after years of searching the libraries and Mike's records, still says she has only a limited understanding of the implications of this diagnosis.

When the time came for Mike to go to school, his social worker recommended a local treatment center, which was a special, private school serving children with emotional problems and learning disabilities. The tuition was over $1,000 per month, but included the educational program and related services. In Mike's case this meant individual psychotherapy and family counseling.

At that time, because there were no programs for emotionally disturbed children, the state had funds available for private placements. Parents paid tuition on a sliding scale, and the state provided the balance. However, many of the emotionally disturbed children were being sent to schools in other states. Mike's parents had him evaluated by the treatment center, enrolled him, and then applied for tuition support. It was then that the mother says she began her education in

> the cold, cold world of state politics, school board deceit and double talk, and bureaucratic red tape. I learned to recognize when I was being put off, put down, and when I was being lied to. Unfortunately, recognizing it is easier than doing something about it. The feelings of helplessness are overwhelming and serve to enforce the intimidation.

Mike's mother continued several months of what she called "game playing" with the school board. Finally, with school about to begin and no placement for Mike, his mother began to call the school board, the state special education director, local politicians, state legislators, and finally the governor's office. She had written letters to all of these people earlier, and many had contacted the school board, but still the school board took no action. She felt she was "begging" for services and describes that period as humiliating and very depressing.

The call to the governor apparently set things in motion, for the parents were informed that Mike could receive funds for the special school and so he was enrolled. However, for several months, the parents would receive conflicting letters—one saying Mike had tuition, another denying funds. Because of this uncertainty, the parents began to explore parochial schools. Mike was turned down at each school. Furthermore, Mike's mother felt that the various principals were totally unsympathetic. While they had programs for the mentally retarded, learning disabled, and neglected children, no one would take an emotionally disturbed child.

Mike's mother was particularly upset about the general insensitivity of the churches to her plight. Mike was even denied Sunday school in their own church because of his behavior, and his mother had to arrange a special Sunday school class taught by a special education teacher from the congregation.

Mike was able to remain in the special school and did well. The principal and teachers were described by his mother as excellent and dedicated. Mike's teacher was very helpful to his parents. For the first time they were kept informed of Mike's progress, including his therapy. Also, the teacher spent much time helping them understand Mike and how to work with him. His mother said that she began to gain confidence in her ability to deal with Mike.

During Mike's second year at this school, PL 94-142 came into effect, and the school board began to remove children from the private schools. Mike's mother became involved with other parents in an extensive lobbying effort to keep the schools open. They wrote letters, sent telegrams, and met with state legislators. They organized a number of fund-raising events, both to help the school and to create public awareness. Mike's mother remembers one meeting in particular. It was with the Assistant Superintendent of Special Education for the state who told the parents that certain state legislators were furious at them, that the name of their parent organization was too similar to another parent group and they probably were going to be sued, and generally intimidated and "bullied" the parents. Again Mike's mother said that she was humilated and angry.

Despite the parents' efforts, the private treatment center closed, and Mike's parents had to face the ordeal of finding a placement in the public schools. A year before the closure of the private school, Mike's first IEP was done, which his mother describes as an "assembly-line" procedure. When the parents arrived for their appointment, they found the lobby full of waiting parents. Each parent was handed a form that essentially asked him or her to agree to a placement. There was neither IEP nor was any placement specified. Mike's parents refused to sign and were told that an IEP meeting could not be held until Mike had an evaluation. When the meeting was held, the school board attempted to change Mike's diagnosis as well as his placement. However, the principal, teacher, and therapist from the private school were able to prevail and Mike was allowed to return to the private school.

As harrowing an experience as that was, Mike's mother said the next year's IEP meeting proved even more difficult. Despite the parents' efforts, the private school had closed. The parents had exhausted all of their options and had no choice but to try for the best possible placement in the public schools.

> We must have gained a reputation because they brought out their heaviest "guns." There were three or four (I cannot recall) supervisors present at our IEP, each with expertise in some related area pertinent to our case. We too had our heavy ammunition. We had the principal, Mike's two teachers, Mike's therapist, our counselor, Mike's private psychiatrist (who monitors his medication), and

> Mike's private occupational therapists. It was a grueling three hours of fighting on each point. We knew we had to compromise and compromise we did.

The parents agreed to provide private psychotherapy and occupational therapy as well as any family counseling. The school board agreed to place Mike in a new model school program in a neighboring school district, but the parents had to provide their own transportation. The schools did agree to provide minimal occupational therapy; however, this was inconsistent, and in one year, Mike had only three sessions. Several years ago, during a meeting of a local parent organization, Mike's mother questioned a school board member about this issue of related services. She was told that parents should not expect "Cadillac treatment."

Mike remains in the public school program and is surviving. However, his mother feels that he is not performing well academically. While his grades are good, he is doing work that he did three years ago at his private school. Mike's mother feels that the special education students are not taken seriously and are not challenged academically. Not only are there academic problems with Mike's school program, but the general environment of the school is filled with violence, including student's use of knives and guns. Mike has suffered abusive taunting at the hands of schoolmates, and his life has been threatened. Not only do Mike's parents fear for his safety, but even for their own when they pick him up from school. Mike's mother arrives at school 15 minutes before the end of the day to avoid encountering the general student body.

In addition, Mike's first home-room placement was into a class including violent behaviorally disordered children who had been in trouble with the police; one student was on parole. Mike has since been placed into a more appropriate home-room setting, but the overall school environment remains threatening.

Mike sees a private psychiatrist once a month to monitor his medication. After episodes involving detrimental side effects of various medications, Mike's parents have learned that medications must be diligently monitored, not only for behavioral effects, but also for potential physiological damage. He also has weekly therapy sessions with a private social worker. His parents pay for these services, and over the past few years have approached the school about providing therapy, but to no avail. Once, when they pushed the issue, they were told in a threatening manner that if Mike really needed these services so badly, he could be institutionalized. The threat of institutionalization was posed by various professionals to not only Mike's parents, but to other parents who also "pushed" the system for what they felt were appropriate services.

Overall, Mike's parents remain hopeful that effective treatment for Mike's condition will be discovered. However, they are bitter about what they see as lack of movement in the professional fields associated with mental illness. His mother comments,

> I am hurt by their apparent lack of caring. I am outraged by their lack of move-

> ment as a body of professionals to try to improve the conditions of the lives of their patients. They could do much to dispel the fear and hatred that the public feels for mental patients. This fear and hatred is demonstrated everyday in movies, TV presentations, etc., which depict mentally ill patients inaccurately and with no compassion. They, in my opinion, discourage the joining together of families of mental patients to work for changes. But most important, some pressure needs to be put on government to provide programs that are needed (MORE MONEY IS SPENT ON *DENTAL RESEARCH* THAN ON THE CAUSE AND CURE FOR MENTAL ILLNESS). Insurance is unfair to mental patients (our insurance pays one-half of one visit to the psychiatrist with a limit of $12.00 each month (12 per year only). Not one penny of the social worker's bills are paid and this is disgraceful. Mental illness is just that, an illness, but is treated like a crime. Even treatment for alcoholism is paid for by most insurance companies—surely a disease as debilitating as schizophrenia should be covered.

With respect to the education professionals, Mike's mother considers that the major problem is with the administrative personnel, most of whom she feels are ineffective and unwilling to help. "Mike has had some fine teachers, (but) the administrators are too concerned with their images, their budgets and their careers to care for the children." She also resents the lack of communication over the past years. The most helpful people have been those who are direct and honest. "It would have saved a lot of pain and perhaps meant more rapid progress if we had been dealt with as adults with honesty and candor. We would have liked it if the terms they were throwing at us had been explained."

Mike's parents have spent a great deal of time working with him at home. His mother reads to him daily as she has since he was two years old. She spends several hours a day with him listening to music or playing. Mike is becoming more withdrawn, and it is more difficult to make contact with him, but his parents continue to keep him involved in scouting, concerts, movies, and exposing him to new experiences.

> I enjoy my child and even his illness has not diminished the joy and enrichment he has brought into my life. Yes, we do get tired of the therapy appointments, the problems with schools, the times when he is in crisis, the demand on our time, but he is a great kid and we enjoy having him in our lives—work and all. Having Mike, with his problems, was a factor in our decision not to have more children. We felt, and still feel, we have a responsibility to do the best we can for him. We try to keep a balance and sometimes it is hard, as it would be for any one-child family. We chose to have Mike, he was not an accident. So we are ready for the responsibility and we accept it. We enjoy every stage of his development, we savor every phase—raising a child is what we wanted to do. Yes, there is pain when we think about his future—Will he be able to have a life of his own? Will he be able to marry? Should he have children? Will we miss out on being grandparents? These things are painful to think about. But we have Mike now and we try to live now and do the best we can and try to have as happy a life as we can NOW.

The greatest concern for the parents at this time is for Mike's safety in school. They feel that he is vulnerable, and that the public school presents a life-threatening situation, filled with violence and abuse. This setting is totally inappropriate for Mike, characterized by his mother as "gentle and docile." Private and parochial schools offer no hope, as they do not have programs for emotionally disturbed children. Their next major concern is for his education. They feel that Mike is not being equipped to function in life. They fear that he will have no job skills and might not be able to be independent as an adult.

The foremost recommendation made by Mike's parents was for honest and open communication between schools and parents. They feel that parents should be trusted and not discounted. Professionals should learn to value parents' perceptions and experiences. In turn, parents need information so that they don't fall prey to "quacks" and fads. They also need to understand their rights and those of their children better. For if they are informed, parents can make better decisions and better judgments about what is best for their children. Children are parents' responsibility, not some school's or agency's, and parents cannot fulfill this responsibility if they remain ignorant.

Summary

These histories have more than adequately addressed the struggle that has existed between parents and schools. Although brief, they are rich in detail. While any attempts at summarizing or proselytizing is likely to be superfluous, a few comments seem in order. First, while these parents were not selected through a sampling process, their comments and perceptions are, in this author's experience, remarkably similar to those which have been expressed by other parents of handicapped children in many contexts (see Noel, in press; Peters & Noel, 1982).

The fundamental issue that emerges from all such conversation with parents is the mistrust that exists between schools and parents. Consistently, parents report not trusting school personnel, while also recognizing that their own experiences and opinions are not trusted by the schools. Such mutual distrust can only lead to the development of destructive, adversary relationships.

Interestingly, the two parents interviewed for this case history differed somewhat in their opinions of teachers. Debbie's mother had strong negative opinions, whereas Matt's parents felt that teachers were basically responsible and were doing a good job, but that the administrators were considered generally deceitful and lacking in concern for children. The latter perception is more consistent with those of other parents. In fact, it has not been unusual for parents to feel sorry for teachers whom they see as victimized and manipulated by administrative personnel. However, as stated in the introduction, these interviews present only one side of a complex story. Furthermore, the intent of this chapter was not to lay blame or to instruct professionals on how to work with parents. Rather, the intent has been to contribute to the awareness of the parent in education and to provide an opportunity, in the midst of professional opinion and conjecture, to recall that the real target of all our efforts is the education of children—a complex problem that professionals and parents must face . . . together.

Reference List

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